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An Exploration of Emotional Well-Being
From a Coping Perspective

by

Tina-Linnea Nelson
B.A., University of Montana, 1988
M.A., University of Northern Colorado, 1991

A Dissertation Submitted in Partial Fulfillment of the
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We accept this dissertation as conforming
to the required standard

Dr. C.B. Harvey, Supervisor (Department of Psychological Foundations)

Dr. J.Ø. Anderson, Departmental Member (Department of Psychological Foundations)

Dr. R.V. Peavy, Departmental Member (Department of Psychological Foundations)

Dr. E.D. Pittaway, Outside Member (School of Social Work)

Dr. J.A. Walsh, External Member (University of Montana)

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University of Victoria

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Supervisor: Dr. C. Brian Harvey

ABSTRACT

The primary purpose of this explorative study was to develop a therapeutically relevant theory of emotional well-being. The developed theory focuses on coping skills because they are observable, measurable, and teachable. The secondary purpose of this study was to begin researching other important aspects of human nature that may impact emotional well-being. As a foundation to this study, stress and coping theories were reviewed. Contemporary theories concerning coping styles were applied to current conceptions of emotional well-being. The author developed the Well-Being Pilot Test (WBPT) to serve two functions. The WBPT was devised to obtain a useful understanding of the composition of emotional well-being in terms of coping skill divisions. The second function of the WBPT was to begin exploring spiritual, physical, and intellectual health and how they relate to emotional well-being. The WBPT consists of 273 items and was given to 370 people in the United States. The results of this explorative study yielded five coping skill divisions associated with emotional well-being: interpersonal, intrapersonal, stress regulation, emotional stabilization, and problem solving skills. Results of this study are discussed in terms of their usefulness in the therapy session for both, the psychotherapist and the client. The results also indicated that all three of the chosen aspects of human nature (i.e., spiritual, physical, and intellectual health) were significantly related to emotional well-being. Intellectual health was most strongly related to emotional well-being, followed by physical health, and finally, spiritual health. This explorative study, thus, provides pertinent information for the psychotherapist regarding therapeutically relevant conceptualizations of emotional well-being. The information gained from this study will help the psychologist move away from the focus of decreasing emotional sickness to one of encouraging coping skills designed to enhance emotional wellness.

Key Words: Emotional well-being, coping skills, stress, wellness, depression, interpersonal, intrapersonal, problem solving, emotional stabilization.

Examiners:

Dr. C.B. Harvey, Supervisor (Department of Psychological Foundations)

Dr. J.O. Anderson, Departmental Member(Department of Psychological Foundations)

Dr. R.V. Peavy, Departmental Member (Department of Psychological Foundations)

Dr. E.D. Pittaway, Outside Member (School of Social Work)

Dr. J.A. Walsh, External Member (University of Montana)

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An Exploration of Emotional Well-Being

Introduction

Goals of this Explorative Study

The primary purpose of this explorative study was to develop a therapeutically relevant theory of emotional well-being. Emotional well-being refers to the continuum of psychological health; from depression to emotional wellness. The theory was accomplished both, by developing the Well-Being Pilot Test (WBPT) which was specifically designed to test various aspects of emotional well-being, and by consulting current research concerned with emotional well-being and coping styles. The coping perspective was chosen because it is readily applicable to the therapy session. Some wellness theorists offer intellectually relevant conceptions, but use terms and concepts that are not applicable to the therapy session. For example, Witmer and Sweeney (1992) offer an in-depth theory of wellness, but use intellectualized taxonomy such as: oneness and the inner life; sense of worth; love; and, friendship. These notions are, undoubtedly, relevant to emotional well-being, but it is difficult to translate "oneness and the inner life" into a specific goal for psychotherapy. A theory of emotional well-being, therefore, must be based on reportable and observable areas of difficulties or competencies. Once this is accomplished, one can identify coping skills associated with each of the core components of emotional well-being. Thus, a better understanding of emotional well-being will allow the psychotherapist to focus on specific coping skills to use as interventions, emphasizing the core areas of emotional well-being in which the client is deficient in effective coping skills. The therapy client will, hopefully, be left with usable and effective coping skills for future difficulties.

As this is a new branch of research, a literature review is presented that focuses primarily on the relationship between coping and emotional well-being. The theoretical foundations of stress and coping are offered. The most prevalent theories are discussed and compared. A review of current research concerned with stress, coping, and

personality traits and how each potentially relates to depression and emotional wellness is presented. Several theories of depression which consider ineffective coping as a primary element to the development of the condition are emphasized. Gender differences are considered in relation to coping styles and to how they may be linked to the expressed gender differences in depression. Subsequently, a review of the emotional wellness research is offered. The wellness review emphasizes coping styles and personality traits that may be associated with emotional wellness.

The secondary purpose of this explorative study was to begin researching other important aspects of human nature and how they may be related to emotional well-being. Many wellness theorists include concepts concerned with spirituality, work, and physical health, such as Witmer and Sweeney (1992). Again, the primary purpose of this explorative study, was to obtain a therapeutically relevant understanding of emotional well-being. It is also, however, important to begin an exploration of emotional well-being in relation to a person's spiritual, intellectual, and physical health. The purpose of this exploration is not to establish that spiritual, intellectual, and physical health are three distinct factors separate from emotional well-being, but rather, the goal is to begin to explore the relationship of how each of these important aspects of human nature relate to emotional well-being. This goal was accomplished both, by developing the Well-Being Pilot Test (WBPT) that contains items specific to each of four important aspects of human life (i.e., emotional well-being, spiritual health, physical health, and intellectual health) and by consulting relevant research. The knowledge gained from this exploration will be helpful for the psychotherapist because it will provide pertinent information regarding other aspects of human nature that may impact a client's emotional well-being.

A review of the research that was consulted for the exploration of the important aspects of human nature associated with emotional well-being is provided near the end of this literature review. The research is presented in terms of the areas of human nature that other researchers have believed to be important, which determined both, how

spiritual, physical, and intellectual health were chosen for the WBPT, and how the item content of each area of human nature was determined. Finally, a description of each aspect of human nature that was chosen to be explored in this study, is provided.

In conclusion, this explorative investigation of emotional well-being and related aspects of human nature, will function to provide a concrete focus for the psychotherapist in the therapy session. This focus will be concerned with the determined core areas of emotional well-being. A psychotherapist may approach a client's treatment with the goal of helping the client to develop specific coping skills related to the areas of coping weaknesses. The enhanced skills should help the client to cope effectively with similar situations and, perhaps, prevent repeated use of ineffective coping skills. The client, therefore, will have gained usable and effective coping skills.

A Brief Review of Emotion and Stress Research

When considering the breadth necessary to establish a firm foundation of definition and theory concerning emotional well-being, the most logical place to begin is with the concept of stress. The word "stress" appears to have many different definitions and connotations. It seems that one cannot open a journal and not see the word stress. This introduction presents the most prominent theories of stress and discusses how people cope with stress. Current research relating coping patterns with the tendency to develop depressive symptomatology is also reviewed. Similarly, research regarding coping styles and personality traits that are effective and associated with wellness is presented.

It is obvious that stress, coping, personality, depression, and wellness overlap considerably. It may be, therefore, more sensible, and ultimately more comprehensible, to consider the theoretical evolution of coping and emotional well-being research. This consists of a discussion of theories concerned with stress, coping, depression, emotional wellness and, more specifically, how coping relates to emotional well-being.

The concept of stress has been recognized for thousands of years. Just as the threats of nuclear war, natural disasters, and everyday struggles are perceived as stressful in the late twentieth century, so was the threat of animal attacks, diminished food supplies, and adequate shelter stressful centuries ago. It has been estimated by the American Academy of Family Physicians, that two-thirds of all office visits to general practitioners were for stress-related symptoms (Santrock, 1991). The association between stress and medical illness shows the physical impact of stress. Stress is theorized to be a crucial determinant in the development of cancer, lung difficulties, coronary disease, thyroid disease, alcoholism, suicide, depression, and anxiety. Interestingly, the term "stress" has only become popular in research journals and books, self-help books, and pop media in the last four to five decades.

Nearly every profession has attempted to define stress. The word "stress" appears to be a catch-all term for many different ideas. There are currently several domains of stress that are being specified: environmental stress; cultural stress; job stress; family stress; noise pollution; stress resulting from increased crime rates; and, racial tension. Santrock (1991) offers a simple definition of stress, "stress is the response of individuals to the circumstances and events, called stressors, that threaten them and tax their coping abilities" (p. 550).

Theories of emotion were the foundation for theories of stress. An examination of this evolution, from emotion to stress to coping, is provided in this introduction. One of the earliest theories of emotion, which served as the springboard for substantial research, was originally proposed by James in 1884 and then expanded in 1890. He asserted that human emotions were the result of the perception of an event that led to a change in physiology, which led to an emotional experience. For example, according to the theory, a person running from something would deduce that the experienced emotion must be fear. Lange (1887) independently proposed a similar theory of emotion. His theory placed more emphasis on the changes within the body than James' theory. Lange

considered emotions to be the result of experienced changes in bodily responses, such as arousal. The theories have become known as the James-Lange theory of emotion (1922).

Many researchers criticized various aspects of the James-Lange theory (Cannon, 1927; Munsterberg, 1892; and, Titchener 1914). Cannon (1927) criticized it by focusing on the physiological arousal resulting from situations perceived as stressful. He discovered that physiological responses to emotionally provoking events were extremely similar, no matter the situation. He concluded that one could not label an emotion based on awareness of bodily arousal alone.

More current research emphasizes cognitive appraisal and emotion (Lazarus, 1966). Lazarus emphasized the process with which people manage stress. He observed that emotional appraisal of a stressful event was adaptive, in that it provided increased information. This research led to a cognitive theory of emotion (Lazarus, Averill, & Opton, 1970). At roughly the same time, Schacter and Singer (1962) demonstrated that people that were injected with adrenalin, producing a sympathomimetic effect, labeled their emotion based on their interpretation of the situation (when unaware of the expected side-effects of the injection). The research supported the need to add a cognitive component to a theory of emotion.

The most influential theoretical contributions in stress research has been by Hans Selye (1936; 1946; 1956; 1974; 1976a; 1976b; 1979; and, 1980). Selye (1980) offered this definition of stress "the nonspecific (that is, common) result of any demand upon the body...". Later, he continued with "...be it a mental or somatic demand for survival and the accomplishment of our aims" (p. vii). He developed the term "stressor," defined as, any situation that provokes a stress response. In the preface of the 1980 book, he discussed several aspects of stress that are often confused and misrepresented in research. Selye considered stress as being nonspecific. That is, stress cannot be observed in isolation: a stressor must precede the experience of stress. He acknowledged that a stressor is only a stressor if a person appreciates it as such. This point will be discussed

at length in later sections of this paper that focus on research by Lazarus and Folkman (1984). Selye believed that the stress response was very similar in all people, regardless the source. He continued by stating that "both internal and external predisposing or immunizing factors modify the response" (p. x). Internal predisposing factors may include genetic predisposition and/or prior experience with certain stressors. External factors may include air or noise pollution and culture. Internal predisposing factors are discussed at length in this introduction in terms of personality characteristics and coping patterns in combination with the person's appreciation of stressors.

Selye (1980) delineated two types of stress: "eustress," meaning good stress; and, "distress," which is stress resulting from negative experiences. Eustress may be experienced, for example, when one learns that he or she has just won the lottery, and distress may result from learning that one owes more taxes than originally thought. Selye emphasized the point that eustress and distress are based on how the individual interprets the stressor situation. Distress to one person, therefore, may be eustress to another. For example, a young woman that discovers she is pregnant may find this situation either eustressful or distressful, depending on her situation. It is also important to note that stress is a matter of degree. Selye stated that stress is not a black and white phenomenon. He also offered a treatment goal, "...I believe that the greatest challenge to humanity at present is to find a philosophy of life, a code of behavior, which gives good guidance, not to avoid stress (for that is impossible), but to cope with it in order to achieve health, long life and happiness" (p. xii).

Selye (1936) referred to the universal physiological reactions provoked by a stressor, or a demand, as stress, and called the reactions the General Adaptation Syndrome (GAS). The GAS is composed of three stages of response to any stressor. The first response is the alarm stage, where the body enters a shock phase in which it works to protect itself against the detected stress. The individual experiences a decrease in muscle tone, body temperature, and blood pressure. The second response is the resistance stage,

that consists of increased bodily response to stress. In this response, there is an increase in blood pressure, heart rate, and respiration. If this response does not succeed in helping the individual eliminate or modify the stressor, it is followed by the exhaustion stage. Here, the body is not able to sustain the efforts and begins to show wear and tear. The individual becomes more susceptible to illness and may collapse.

The psychological aftermath of World War II and the Korean war presented opportunities to study stress responses in the service men. It became apparent that they did not respond uniformly to the stress associated with combat. It became evident that individuals have different tolerance levels for stress, and utilized different procedures for coping with stress. This finding instigated literally thousands of laboratory experiments on the effects of stress on an individual. Lazarus and Eriksen (1952) found that certain personality characteristics were crucial in understanding how stress affected people, or stated more appropriately, how they would interpret and respond to stress.

The research from the 1950s, 1960s, and 1970s has led to investigations of many aspects of stress. Stress-related illness research has progressed into the large field of psychoneuroimmunology. This field is concerned with how the brain, the immune system, and behavior interact. Much of the research emphasizes how the psychological aspects of a person leads to physical illness. A more holistic understanding of depression is being considered by researchers that are investigating the neurochemistry, neuroendocrinology, and the psychoimmunology of affective illnesses. For reviews on these topics the reader is directed to (Ader, & Cohen, 1993; Brown, 1989a; Jones, 1989; Kupfer, 1989; Nair, & Sharma, 1989; Richardson, 1989; Rubin, 1989; Schleifer, Keller, Bond, Cohen, & Stein, 1989; Steiner, 1989; and, Weisse, 1992).

Another related avenue of research, emphasized how people interpret an event as being stressful. Selye (1980) stated that a stressor is only a stressor if it is appreciated as such. This work has been expanded upon by Lazarus and Folkman (1984). Lazarus and Folkman (1984) have focused on two key aspects of stress research: the person's

interpretational process of events; and, the response to the perceived stressor. This research has led Lazarus and Folkman (1984) to develop a cognitive theory of stress and coping.

Lazarus and Folkman (1984) described three classical definition orientations of stress: stimulus definitions; response definitions; and, relational definitions. Stimulus definitions center on the belief that the stressor, or the event leading to stress, is damaging to the individual in some manner. Lazarus and Folkman (1984) refer to earlier work presented by Lazarus and Cohen (1977) and discuss three types of stress stimuli: catastrophic stress that involves many people; catastrophic stress that only involves the target person or only a few people; and, stress that occurs in every-day life, which they term "daily hassles." When considering a stimulus oriented definition of stress, one must also consider the issues related to the stressful stimuli. This includes the intensity, duration, controllability, and the frequency of the stimuli. Related to this, but slightly different from Lazarus and Folkman (1984), Elliott and Eisdorfer (1982) suggested four types of stress provoking stimuli:

> (1) Acute, time-limited stressors, such as...awaiting surgery,...; (2) stressor sequences, or series of events that occur over an extended period of time as the result of an initiating event such as job loss, divorce, or bereavement; (3) chronic intermittent stressors such as conflict-filled visits to in-laws or sexual difficulties, which may occur once a day, once a week, once a month; and (4) chronic stressors such as permanent disabilities, parental discord, or chronic job stress, which may or may not be initiated by a discrete event and which persist continuously for a long time. p. 150-151

Selye's definition (1980), "the nonspecific (that is, common) result of any demand upon the body..." (p. vii), is a response definition. Lazarus and Folkman (1984) asserted that by defining stress using a response definition, one does not provide an indication of what causes the response. It is only the response that is considered. Consider a person

experiencing an increase in heart rate and blood pressure. The response could be a genuine "stress response," or the response to being too warm, or to increased physical exercise. Selye (1980) offered no guidelines to defining the stressor. In this case, temperature or physical exercise could be considered a stressor.

Lazarus and Folkman (1984) state that "It is the observed stimulus-response relationship, not the stimuli or response, that defines stress" (p. 15). They offer this relational definition of stress:

> Psychological stress is a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being. The judgment that a particular person-environment relationship is stressful hinges on cognitive appraisal... p. 21

Smith (1993) also considered a relational, or transactional approach, to defining stress. He offered several methods to study both the response to stress, and the stressful event itself. He asserted that one needs to consider the content of the stimuli: the context of the event; the undesirability; and, the psychological magnitude, in order to better understand its impact. He considered catastrophic stress and daily hassles, and asserts that a person will cope differently with these stressors. Smith (1993) emphasized that the ambiguity of events: the unpredictability; uncertainty; and, uncontrollability, greatly influence the person's response to the stressor. He also considered the timing of the events, imminence and duration, to be important in determining an individual's response. Thus far, stress has been defined several different ways. It can be concluded that many factors need to be considered (e.g., the stimulus, the response, and the relationship) to obtain a better understanding of stress for the purposes of better understanding emotional well-being.

Current research centers on the individual's appraisal process, that in part, determines whether a stimulus is experienced as being stressful. There are many avenues of research that consider the appraisal process. The process involves appraisal biases,

different stages of appraisals, and the actions taken (coping response). The current research regarding stress leads naturally into a discussion of the coping processes.

Brief Review of Research Concerned with Coping Processes

The most pertinent theories of coping are presented here. This review serves to introduce the reader to the theoretical foundations of the theories concerned with coping. There seems to be two principal domains when considering coping research and theory. Some emphasize traits and stable characteristics of a person that determine the way he or she copes with stress (e.g., Antonovsky, 1979; Bandura, 1982; Carver, & Scheier, 1981; Greenburg, & Pyszczynski, 1986; and, Kobasa, 1979). Personality styles and traits have been shown to be associated with different affective states. The proposed coping traits are discussed in the body of this paper. A second domain of the research emphasize the situation and the appraisal process which determine the coping process (e.g., Lazarus & Folkman, 1984). This area of research is considered after a more thorough discussion of the association of personality traits and coping styles, which serves to complete the bridge between stress and coping research.

The most influential and researched relational model of appraisal and coping was proposed by Lazarus and Folkman (1984). The definition of stress presented by Lazarus and Folkman (1984) discussed it in terms of cognitive appraisal and coping processes. They explained cognitive appraisal as the "...process of categorizing an encounter, and its various facets, with respect to its significance for well-being" (p. 31). They continue with "...it is largely evaluative, focused on meaning or significance, and takes place continuously during waking life" (p. 31). Coping with a single event, be it complex or simple, is individually unique. This is not to imply that there are as many coping strategies as there are situations and people. The notion of modifying the coping response to suit the individual is where Lazarus and Folkman (1984) branch away from early stress researchers, that emphasized typical responses to stress.

Lazarus and Folkman (1984) defined coping as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). They also stated, "coping serves two overriding functions: managing or altering the problem with the environment causing distress (problem-focused coping), and regulating the emotional response to the problem (emotion-focused coping)" (p. 179). They theorized four modes of coping: "direct action; inhibition of action; information search; and, a complex category referred to as intrapsychic, or cognitive coping" (p. 318). The separation of problem- and emotion-focused coping is somewhat controversial.

Lazarus and Folkman (1984) identified three stages of cognitive appraisals: primary appraisal; secondary appraisal; and, reappraisal. Primary appraisal is the judgment a person makes about an event. According to this theory, there are three possible primary appraisal categories: harm/loss; threat; and, challenge. Secondary appraisal is the judgment a person makes about what to do in the face of the situation (e.g., the coping strategy). Reappraisal follows a previous appraisal. A person, therefore, reappraises a situation when he or she has acquired more information about the situation.

Lazarus and Folkman (1984) also discussed psychological factors that effect the cognitive appraisal process. They point out that the cognitive appraisal process is not necessarily conscious. According to Lazarus and Folkman (1984), the most influential components of appraisal to consider are commitments and beliefs. A commitment is something that an individual believes is important. The depth of the commitment may vary, but it is the commitment that shapes the way a person appraises situations. The commitment may highly motivate the person to resolve a situation, or may influence a person to avoid encountering certain situations. Beliefs also determine the situations people encounter and how they appraise their surroundings. An individual's belief regarding his or her ability to control a situation is paramount to the coping process (discussed in detail in a later section). For example, if a person perceives that he or she

can effect some control over the situation then this belief is stress reducing and encouraging for the individual. The antithesis, however, is also true. Pinderhughes (1983) has also explored the issues of control, or empowerment, as being fundamental to the coping process. Pinderhughes states "...the goal for all clients may be conceptualized as empowerment--the ability and capacity to cope constructively with the forces that undermine and hinder coping, the achievement of some reasonable control over their destiny" p. 334. Existential beliefs also influence an individual's coping process. For example, people can create meaning and give purpose to difficult situations, thereby reducing stress (Brink, 1993; Maton, 1989; Miller, 1993).

Lazarus and Folkman (1984) also discussed situational variables that may influence the appraisal process and outcome. The following play an important role in the appraisal process: the novelty; unpredictability; and, uncertainty of a situation (Rosenbaum, 1990). For example, if a person has had prior experience with a similar current situation, one needs to consider the consequences of that first encounter. The factors proposed by Rosenbaum (1990) may be prudent in determining how a person copes with similar future encounters.

Lazarus and Folkman (1984) also stated that the appraisal process is influenced by: the imminence (high imminence increases the urgency of appraisal); the duration of the event (this is similar to the conception behind Selye's General Adaptation Syndrome); and, the temporal uncertainty. Temporal uncertainty refers to ambiguity regarding the timing of an event. For example, having the knowledge that many people will be released from company employment, but not knowing when the news will be conveyed, taxes the coping responses. Lazarus and Folkman (1984) also discuss the ambiguity of events. They stated that the more ambiguous the event, the more the person must extrapolate, which greatly influences the appraisal process. A person's health, mental and physical, is also important to consider with regards to his or her coping capacity. For example, if a person is feeling physically sick, he or she may only have a limited capacity

to cope effectively. Some psychological and situational factors that influence the appraisal process were considered, which leads to a discussion of the coping responses themselves.

The coping response can be defined as, the cognitive and behavioral responses to stressful events. Lazarus and Folkman (1984) proposed three important aspects of coping: occupational and social functioning; morale; and, somatic health. First, an individual's occupational and social functioning are greatly influenced by the manner in which he or she appraises, and copes with, a situation. A person that tends to cope adaptively, is likely to be capable in occupational and social situations, and less likely to misappraise situations which can result in misunderstandings with others or poor occupational functioning..

An individual's morale and life satisfaction are also important factors when considering the coping process. Morale results from the individual's beliefs of how well one has met one's goals and how satisfied he or she is with the actions taken (Lazarus and Folkman, 1984). One could consider "learned helplessness," originally described by Seligman and Maier (1967), as a coping process that contributes to a low moral. Seligman and Maier (1967) theorized, based on animal models, that learned helplessness led to depression, often associated with low morale. For example, a person appraises him- or herself as being unable to affect change on a situation, thereby, leaving them with a sense of dissatisfaction with the result of the situation. Alternatively, a person pleased with his or her response to the situation may be left with a sense of contentment or satisfaction.

Finally, Lazarus and Folkman (1984) hypothesized that a person's somatic health is influenced by how he or she responds to stressful situations both psychologically and physically. This avenue of research largely began with Selye's Generalized Adaptation Syndrome and has grown into the separate, but related, field of psychoneuroendocrinoimmunology. The reader is referred to the following resources for

an introduction to psychoneuroimmunology (Ader, 1983; Ader, Felten, & Cohen, 1990; Kropiunigg, 1993; La Via & Workman, 1991; McDaniel, 1992; Vollhardt, 1991).

Billings and Moos (1981) offered a brief review of the coping research with an emphasis on the definitions for the method a person uses to cope and the focus of the coping. The method of coping refers to active versus avoidant responses to perceived stressful situations. Active-cognitive coping was defined as "...includes attempts to manage one's appraisal of the stressfulness of the event, such as 'tried to see the positive side of the situation'..." (p. 141). Active-behavioral coping was defined as, "...overt behavioral attempts to deal directly with the problem and its effects, such as 'tried to find out more about the situation'..." (p. 141). Billings and Moos (1981) stated that avoidance coping "refers to attempts to avoid actively confronting the problem (for example, ...'kept my feelings to myself') or to indirectly reduce emotional tension by such behavior as eating or smoking more" (p. 141).

Billings and Moos (1981) discussed the emphasis of the coping response, which refers to problem- and emotion-focused coping. The process was also discussed by several other researchers, the reader is directed to Antonovsky, 1979; Lazarus, 1981; and, Pearlin and Schooler, 1978. Problem-focused coping involves the process of actively reducing or eradicating the origins of stress through one's behavior and/or cognitions. Emotion-focused coping refers to either cognitive or behavioral reactions that function to reduce emotional instability and enhance emotional balance. Billing and Moos (1981) based their investigation both on method of coping and focus of coping. Many researchers do not make the same distinctions associated with coping that they propose.

Holahan and Moos (1985) also discussed coping using an avoidant-active distinction for method of coping. For example, they considered two groups of people: a "distressed group" that reported high stress and high distress; and, a "stress resistant group" that reported high stress and low distress. They found that stress resistant people were more "easy going," and less likely to use avoidance coping. Avoidance coping

means that the individual tends to deal indirectly with stressful situations, or not handle them at all.

Suls and Fletcher (1985) considered a process of introspection that they termed "private self-consciousness." It is defined as, "a disposition to focus on covert and internal aspects of the self-moods, emotions, and feelings, and is measured by a subscale of the Fenigstein, Scheier, and Buss Self-Consciousness Inventory [1975]" (p. 470). These researchers, therefore, categorized people coping with stress depending on their pattern of self-attention. They have shown that people who use the self-attention style of coping are more stress resistant than those who do not practice self-focusing techniques.

Peterson and Seligman (1984) considered an attributional reformulation of the learned helplessness theory. They offered a review of the research that showed that people who use an "explanatory style" of appraisal, tend to be more susceptible to depression. The appraisal style involves interpreting, or explaining, negative events as being caused by some internal defect, that is stable, and global. They expanded this explanation into a theory of depression which will be discussed in detail in a later section.

A dual-axis model of coping has been proposed that considered one axis of coping to be active versus passive and a second axis to be social in nature, consisting of prosocial versus asocial coping (Hobfoll, Dunahoo, Ben-Porath, & Monnier, 1994). The theory was recently proposed and has only moderate support. The authors state that this theory needs work but shows promise for future use in coping theory.

Lazarus and Folkman (1984), Peterson and Seligman (1984), and Holahan and Moos (1985), and most of the theories presented here, discuss coping using a process-oriented approach. There are researchers that give more importance to traits and personality, believing that they greatly influence the way people cope with stressful situations. The notion of personality influencing coping is controversial. It is difficult to

distinguish the process by which a person copes from the individual traits and personality styles that influence coping responses.

There has been a great deal of publicity about type A, B, and C personalities. Type A personality has been suspected to be linked to heart disease. Friedman (1969) offered this description of Type A personality:

> ... a characteristic action-emotion complex which is exhibited by those individuals who are engaged in a relatively chronic struggle to obtain an unlimited number of poorly defined things from their environment in the shortest period of time and, if necessary, against the opposing efforts of other things and persons. p. 84

This coping style obviously influences the way people appraise and respond to (cope) stressful stimuli. Type B personality is, unfortunately, less well defined. It is typically associated with the following characteristics: relaxed manner; easy-going; satisfied; noncompetitive; and, content. The "easygoing" style of coping is referred to in research, but is not necessarily termed Type B. For example, Holahan and Moos (1985) discussed an "easy-going" subset of people utilized for their study. Finally, the type C personality has been termed "the Cancer-Prone style." Researchers believe it may be associated with the development of cancer (Morris & Greer, 1980; Temoschok & Heller, 1984; Temoshok, Heller, Sagebiel, Blois, Sweet, DiClemente, & Gold, 1985). The type C personality has been described by Temoshok (1990), "as 'nice,' stoic or self-sacrificing, cooperative and appeasing, unassertive, patient, compliant with external authorities, and inexpressive of negative emotions, particularly anger." For example, a person may be told by an office superior that he or she has done something incorrectly when, in fact, it has been done right. The person with a type C personality may simply agree with, and thank, the superior. Type C people will, likely, let others treat them poorly, without standing up for themselves.

In this section, several points of view regarding coping have been considered. One primary distinction of coping refers to the method of coping. The method of the coping response may be passive or active, or possibly, degree of private self-consciousness. The focus of the coping response may include emotion- versus problem-focused or prosocial versus asocial responding. The goal of this section was to introduce the status and content of the research concerned with coping processes.

Brief Review of Coping and Gender Research

Billings and Moos (1981) studied the role of coping responses and social resources in attenuating the impact of the stress experienced from everyday situations. They devised a 19-item test of coping responses based on previous work by Folkman and Lazarus (1980); Lazarus (1981); Moos, (1976), (1977); and, Sidle, Moos, Adams, and Cady (1969). Billings and Moos (1981) concluded that the test was only adequate. The results showed weak differences between genders and coping responses. The mean age for men was 45 and 43.5 for women. The authors did not provide the age range. Women were more likely than men to report using active-behavioral, avoidance, and emotion-focused coping. Amount of education was also found to effect coping, with more education resulting in the increased use of active-cognitive and problem-focused, and a diminished use of avoidance coping. They also conclude that social resources, the quality and utility, help moderate the perceived stress of an event.

Billings and Moos (1981) stated that men were less inclined than women to use a behavioral-active style of coping ($p < .01$), emotion-focused coping ($p < .01$), and avoidance coping ($p < .05$). Note that these results, although statistically significant, were very weak, accounting for less than five percent of the variance. The authors conclude that education and income also influence coping response styles but do not adequately consider these factors (gender, education, employment status, and income) with the method and the focus of coping. This fact alone, leads to cautious interpretation

regarding the gender differences in coping responses reported by Billings and Moos (1981).

Hobfoll, Dunahoo, Ben-Porath, and Monnier (1994) investigated gender and coping using active versus passive (action dimension) and prosocial versus asocial (social dimension) using a proposed dual-axis model of coping. The authors also considered their conceptualization of two personality traits: "the extent to which a person feels in control of their life;" (p. 53) and, their gender-role orientation. They developed a test, the Preliminary Strategic Approach to Coping Scale (P-SACS), that consisted of 34 items of possible behavioral coping responses. The P-SACS was based on their dual-axis model of coping. The authors tested the reliability and validity of the questionnaire and concluded:

> These analyses lend modest support for the reliability and internal validity of the P-SACS instrument. The Dual-Axis Model of Coping is a viable conceptual framework from which to at least begin to examine coping strategies, although it requires further shaping to truly fit the data." p. 66

With this in mind, Hobfoll et al. (1994) concluded that there was evidence for some gender differences in coping. Women reported more prosocial, assertive coping behaviors, whereas, men reported more aggressive and asocial responses. Active coping was shown to be associated with less emotional distress for both men and women.

Ptacek, Smith, and Dodge (1994) also investigated gender differences in coping. The authors presented the same "stressful" situation to all subjects to establish whether men and women appraised the situation similarly. Their reasoning was that if men and women differ in their appraisals, then coping differences would be due to interpretational process differences. Ptacek et al. (1994) offered their subjects a real and meaningful situation with which to cope, that included preparing and administering a lecture. They considered gender-role orientation and appraisal to ascertain possible differences in the reported coping approaches. Coping was measured by giving the subjects broad coping

category definitions for seeking support, problem-focused, and emotion-focused coping. The subjects reported which of the three categories of coping they used, in what order they engaged in them, and the relative importance of each category. The three coping categories were tested using a MANOVA and statistically significant multivariate effects resulted. The univariate comparisons showed that women reported using social support seeking and emotion-focused coping more than their male counterparts. The authors concluded that the data "...suggests that the lecture task was indeed psychologically similar for men and women" (p. 425) and that, given these results, the argument that gender-coping differences are due to different interpretational processes was not supported.

Section Summary

The purpose of this portion of the introduction was to give the reader a sense of the status of the research concerning stress and coping, in order to lay the foundation for the discussion of emotional well-being from a coping perspective. There seems to be three main areas of investigation. First, some researchers are focusing on the psychophysiology of stress. The intent of this research is to investigate the relationships of behavior, and the nervous, immune, and endocrine systems. The field has many names depending on which systems are being considered, such as psychoneuroendocrinoimmunology, when all systems are of focus, or psychoimmunology when behavior and the immune system are of particular focus. This area of research is exploding: studying personality and neurochemical similarities in people with certain medical or psychiatric disturbances, such as rheumatoid arthritis, myasthesia gravis, impotence, cardiac problems, cancer, depression, and schizophrenia. The increased sophistication in medical evaluations, diagnostic techniques, and statistical procedures will further advance the scientific knowledge of the complexity of the stress response.

A second area of research is concentrated on the process of coping. The field considers coping with catastrophes to coping with the hassles of every day life, which

have been considered in this introduction. The work of Lazarus and Folkman (1984) was extensively reviewed. Their work has served as the foundation for a great deal of the research regarding specific coping styles and depression and wellness.

Within this area of research there seems to be two main avenues of attention: those that focus on the process of coping, and those that consider individual traits that influence the manner in which people appraise and cope with stressful situations. The latter includes the research on sense of coherence, hardiness, and learned resourcefulness. The former, concerned with the process of coping, also seems to be divided into categories. Some researchers make the emotion- versus problem-focused distinction. This implies that at times, individuals may focus on managing the environment and concentrate their attention on external changes (problem-focused) and , even simultaneously, they might focus internally to regulate their emotional response (emotion-focused). Other researchers discuss the method of coping, in terms of actively coping or using avoidance coping. That is, people may choose either an active or avoidant approach to either problem- or emotion focused coping.

A third area of research focuses on the consequences of certain coping styles. Many researchers focus on the physiology of coping and others focus on the psychology of coping. The former includes such conditions as: ulcers, cirrhiasis, psychosomatic disturbances, cancer, heart disease, and more. The latter considers the psychological outcomes of stress and coping. At this stage of scientific research, the psychology of coping is still in its infancy and is extremely complex. Investigators focusing on this avenue of research tend to talk in terms of "good copers" versus "poor copers," or "healthy" versus "unhealthy," and "depressed" versus "well." Unfortunately, even adequate operational definitions of these terms are rarely presented. It is this area of research that is considered in the next section. Specifically, patterns of both appraisal and coping, and how they influence emotional well-being, is considered.

A Brief Review of Depression

This introduction emphasizes unipolar depression, as opposed to manic-depressive disorder (bipolar). The reader is referred to the DSM-IV for the complete diagnostic description of both (American Psychiatric Association, 1994). Major Depressive Disorder, however, is concisely presented here to serve as an introduction. A Major Depressive Episode is characterized by the following guidelines. It is required that the individual has experienced at least five of these symptoms some time during the two weeks preceding the assessment: depressed mood; markedly diminished interest or pleasure in all, or almost all, activities; total body weight change of five percent or more in a month; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or inappropriate guilt; diminished ability to think or concentrate; and, recurrent thoughts of death. The individual is also required to have at least one of the following: depressed mood; and/or, loss of pleasure or interest in his or her activities. The symptoms, secondly, should not be known to be due to an organic factor, and are not a normal reaction to a traumatic event. Thirdly, the person must not experience delusions or hallucinations in the absence of mood symptoms. Lastly, the condition must not be superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS. At times, the phrase "depressive symptomatology" was used to refer to the experience of various symptoms of depression without meeting the full criteria for a Major Depressive Episode.

The determination of the epidemiology of depression is fraught with complications. There are many difficulties associated with counting the number of people with depression. In research, many times, it is not known whether unipolar, bipolar, and/or dysthymia have been included in the total count, or estimate, of depression. Moreover, some people present with intermittent unipolar depression for years, and only later develop the emotional swings of bipolar depression. Some "depressed" subjects may have recently experienced some trauma in which their

depression is normal given the situation, which is not a true "depression" by diagnosis. The apparent ambiguity concerning the epidemiology of depression and other affective disorders is, therefore, a nemesis of conducting research that concerns emotional health and well-being.

Given the above caveats, it has been reported that lifetime prevalence for major depression is five percent (Regier, Myers, & Dramer, 1984). The same study reports that prevalence rates are substantially different when considering age. For example, Regier et al. (1984) found that 8.1 percent of people between the ages 25 and 40 were depressed, and only 1.5 percent of people over age 65. Gender is also an important factor when considering the prevalence of depression. McCormick (1989) estimated that women were roughly twice as likely as men to be diagnosed as experiencing major depression.

Recall that the emphasis of this study was on emotional well-being and associated coping skills. There are, however, many other associated factors that are provided for a more complete picture of the development of depression. Paykel (1982) concluded that an exaggerated number of life events, usually negative external factors, were inclined to precede the onset of depression. One could logically, of course, conclude that an excess number of negative life events taxes most people's coping skill repertoire. Paykel (1982) also considered the magnitude of the event(s), with more extreme events being more likely to foster depression.

Brown and Harris (1978) suggested that the following were predisposing factors for the development of depression: three or more children in the home under the age of 14, no confidants, no employment outside the home, poor marital relations, and loss of mother before the age of 11. They also suggested that socioeconomic status, social class, and education were other components related to the predisposition of depression. The strongest psychosocial contributor to depression was reported to be the excess of negative adverse life events (Brown, 1989b). However, this point has been debated by several

researchers that consider personality traits to be the strongest contributors to depression (Antonovsky, 1979; Brewin, 1985; and, Lazarus & Folkman, 1984).

Another area of research concerning the predisposing factors of depression is concerned with the potential influencing factors of personality on affective states. One study that prospectively followed depressed subjects for two years, found that the level of depression varied significantly over time, but that personality measures and negative cognitions were stable (Schrader, 1994). The author used the Maudsley Personality Inventory (Eysenck, 1959) which yields two scores: neuroticism and extroversion. Though this research was interesting and exemplified the need for further research, it is hardly enough to base strong conclusions on whether personality characteristics are associated with depression. Obviously, the topic of depression is enormous. This introduction has served to present the criteria for diagnosis and indicate some of the psychosocial factors associated with depression.

A Brief Review of Research Concerned with Depression and Coping

In this section, several theories of depression that consider coping strategies to be particularly important are discussed. A thorough review of the theories is beyond the scope of this dissertation, however, the reader is referred to the original resources for more detail. The presented theories are grouped based upon similarity. Beck (1967) offered a cognitive theory of depression that concentrated on specific cognitive coping and appraisal styles particular to people with depression. Comparably, the reformulated theory of learned helplessness (Abramson, Seligman, & Teasdale, 1978) is different from Beck's (1967) theory, but contains similarities concerning maladaptive attribution and/or learning. Thirdly, it is reasonable to consider Rosenbaum's (1980) theory of learned resourcefulness, which emphasizes good coping rather than poor coping which is evidenced in the learned helplessness theory.

The second group of theories center on the issue of focusing on one's self. Each theory has a different perspective on how focusing on the self may be directly related to

the development or prolongation of depression. Three theories are discussed in this section. Rotter's (1966) notion of locus of control warrants mention when discussing depression. This theory considered an internal or external locus of control for certain issues. The more recent work of Nolen-Hoeksema (1991) concerned with ruminative response styles is also presented. This theory is concerned with focusing on one's mood as a contribution to the length of depression. Thirdly, work by Suls and Fletcher (1985) which focused on private self-consciousness is offered. This theory is concerned with the use of the ability to focus one's attention on his or her mood, bodily sensations, and behavioral responses.

The third group of theories cluster around the issue of self-attention after success or failure. Carver and Scheier (1981) offered a theory of self-regulation which is presented. This theory emphasized what people think to themselves after success or failure. The discussion of the theory is followed by a consideration of a theory proposed by Greenburg and Pyszczynski (1986) who have modified the theory presented by Carver and Scheier (1981). The purpose of the following review was to introduce theories of depression that consider coping with stress to be an integral part of the development of depressive symptomatology.

The emphasis of cognitive theories is on the cognitions of the depressed person. According to Beck's theory (1967), people with depression have a tendency to subscribe to negative, or distorted, views of reality. The distortions of reality influence the manner in which people interpret and respond to situations they encounter and, potentially, leads to maladaptive problem solving. The cognitive-oriented clinician seeks to identify the maladaptive assumptions a person has which interferes with adaptive problem resolution. The depressed person, typically, retains the negative assumptions, even in the face of contradictory evidence. For example, an individual may have the following maladaptive assumption, "I'm no good at communicating with people." The counselor may encourage the individual, through questioning, to obtain more information about the presumed

communication inefficacy. The person may discover that he or she communicates well, except when fatigued. The therapist, therefore, helps the individual discover his or her reality more clearly, by the process of uncovering global assumptions that are maladaptive. This theory emphasized present situations and is not concerned with how the thinking patterns developed. It is focused, rather, on finding the solutions to current events.

Beck's (1967) theory can be discussed in terms of coping theory, using terminology that is consistent with the taxonomy of the coping response used by Lazarus and Folkman (1984). The distorted thoughts may be considered appraisal biases that markedly influence a person's primary, secondary, and reappraisal processes, as well as, influence the situations a person encounters. A person with the maladaptive assumption that he or she is a poor communicator may tend to avoid public speaking, and may choose a profession that requires little communication. For example, the person may view a seemingly harmless chance encounter in a coffee-room as stressful, due to the belief that he or she does not communicate well (primary appraisal). Upon reflection, the individual may decide that leaving the room is the best coping strategy (secondary appraisal). The person may eventually conclude that he or she should take a coffee break in an isolated area to avoid chance encounters in the future (reappraisal). The cognitive theories of depression, therefore, fit well with the cognitive-behavioral theories of coping.

Another well known theory of depression is the revised learned helplessness theory (Abramson, Seligman, & Teasdale, 1978). The reformulated learned helplessness theory posits that it is how a person attributes cause to present or past noncontingency that determines how he or she will perceive future contingency. The theory has been applied, most specifically, to depression. The theory states, in this case, that depression results from the individual's belief that outcomes of uncontrollable bad events are autonomous of his or her responses. Each of three dimensions (internal versus external,

stable versus unstable, and specific versus global) enter into the resulting depression. Therefore, if a person attributes the cause of noncontingency so that he or she believes it is due to some internal characteristic, that the personality flaw is stable, and that it is global, then this appraisal will likely lead to depressive symptomatology. For example, if a person fails an exam and attributes cause according to the theory, he or she may have the following explanations, "I'm stupid" (internal), "I always have been and always will be" (stable), and "I can't do anything well" (global). This style of attribution, according to the theory, is likely to lead to depression or depressive symptomatology.

The scope of the learned helplessness theory is more limited than a solely cognitive theory. The parallels when considering coping and depression, however, are apparent. Once again, the explanations (attributions) for noncontingency are appraisal biases and influence a person's coping processes in many ways, thus influencing a person's emotional well-being.

Brewin (1985) reviewed the three traits proposed by Abramson, Seligman, and Teasdale (1978). Brewin offered three studies that supported the notion of internality versus externality and the stability dimension, Meyer (1980); Michela, Peplau, and Weeks (1982); and, Wimer and Kelley (1982). Brewin concluded, "Although there is good support from these studies for the validity of the internality and stability dimensions, the global/specific dimension has not been identified." He also pointed out, however, that these studies had not set out to test the global dimension.

Rosenbaum's (1983; 1990) theory of learned resourcefulness has also been discussed in relation to depression. Learned resourcefulness is defined as the developed capacity to regulate cognitions and emotions in order to potentiate the successful completion of the target response (Rosenbaum, 1983). The theory is focused on the person's actions toward diminishing the interfering effects of his or her responses to stressors (Rosenbaum, 1990). The theory emphasizes self-control skills and behaviors, and beliefs.

Lewinsohn and Alexander (1990) suggested that the high degree of variability exhibited in response to so-called stressful life events, was largely due to the individual's capacity for learned resourcefulness. They predicted that individuals lacking in self-control skills, problem solving skills, and negativistic beliefs, would be more inclined to develop depressive symptomatology following stressful life events, such as, marital conflict, social exits, and unemployment. They also hypothesized an inverse relationship between the duration of the depressive episode and the level of learned resourcefulness skills. That is, the more resourceful the person is, the shorter the duration of the depressive episode. They offered a third hypothesis, which is related to the first: people who have previously experienced a depressive episode, though not depressed at the time of the study, would score in the low range of learned resourcefulness. They collected data on 806 elderly persons and considered learned resourcefulness, stress, age, gender, and diagnostic category.

The longitudinal study performed by Lewinsohn and Alexander (1990) did not support all of these hypotheses, but nonetheless provided interesting and useful results. They concluded that level of learned resourcefulness predicted future onset of depression. For example, if a person had a low score on the learned resourcefulness measure and was not depressed, he or she was likely to develop depression during the course of the study. Alternatively, if a high score was obtained, the person was less likely to develop depression. Their prediction regarding the duration of depression and the level of learned resourcefulness skills was not supported. They offer these comments "...being high on learned resourcefulness reduced the probability of becoming depressed, but once somebody had become depressed, their resourcefulness level was irrelevant" (p. 214). They did not find support for the third hypothesis. That is, individuals with a history of a depressive episode, but were not depressed at the time of the study, scored the same as the normal controls on the resourcefulness questionnaire. Lewinsohn et al.

(1990) were forced to conclude that learned resourcefulness is associated with "trait" and "state" characteristics.

Lewinsohn and Alexander (1990) also considered gender differences and learned resourcefulness. It was found that women were more likely to be depressed than men, but that women scored higher on learned resourcefulness skills than men. This suggested that these psychological variables do not help account for the gender difference in the epidemiology of depression (Amenson & Lewinsohn, 1981; Lewinsohn & Alexander, 1990).

The next group of theories concentrate on a more narrow range of coping strategies. They are grouped based on the commonality of focusing on the self. Rotter (1966) postulated that locus of control was an enduring characteristic a person has that influences the way he or she acts, feels, and thinks. For example, if a person has an internal locus of control, he or she tends to view the consequences of a situation as the direct result of his or her behavior. Alternatively, a person with an external locus of control will believe that consequences to events are the result of external forces, such as luck, fate, and society.

The individual's locus of control affects his or her appraisal formulation. Therefore, this theory focuses on the beginning of the coping process. Experiments have been designed to test the hypothesis that people with an internal locus of control are better copers. However, there is only limited support for this supposition (Cohen, & Edwards, 1989; Nagy & Wolfe, 1983; Taylor, Lichtman, & Wood, 1984). The theory suggested that people who believe they can influence their environment are more likely to cope effectively. People that view themselves as unable to effect change are less likely to effectively cope, and perhaps, develop depressive symptomatology. In this regard, it is also similar to the reformulated learned helplessness theory.

Nolen-Hoeksema (1991) and, Butler and Nolen-Hoeksema (1994) have studied "response styles" that tend to potentiate depression. The response styles theory (Nolen-

Hoeksema, 1987, 1990) suggested that women remain depressed longer than men, on the average, because of a gender difference in the way men and women cope with depression. Women tend to cope with depression, according to this theory, by focusing their thoughts and behaviors on their depressed mood and the potential causes of the mood. This style of coping is termed "ruminative style" and closely resembles brooding. Men, on the other hand, tend to use distraction techniques, or active coping behaviors and thoughts that may serve to shorten the length of the depressive episode. It is important to note that this theory is not concerned with how the depression develops, but is focused on the maintenance of the depressive episode.

Butler and Nolen-Hoeksema (1994) designed two studies to test, "the hypothesis that women are more likely than men to focus on themselves and their mood when in a depressed mood, and that this leads them to experience longer periods of depressed mood." p. 331. Butler and Nolen-Hoeksema (1994) concluded that their studies, as well as numerous others (Morrow, & Nolen-Hoeksema, 1990; Nolen-Hoeksema, & Morrow, 1991; Nolen-Hoeksema, Morrow, & Fredrickson, 1993; Wood, Saltzberg, Neale, Stone, & Rachmiel, 1990) support their hypotheses.

Butler and Nolen-Hoeksema (1994), however, noted that "degree of rumination is the most important dimension in explaining gender differences in the duration of depressed mood" (p. 341). According to the response styles theory, therefore, men that engaged in the emotion-focused coping mechanism, rumination, were as likely as women that engaged in this response style to have a longer period of depression than those men that used a distraction response style.

The response style theory is rooted in the emotion- and problem-focused distinction supported by Lazarus and Folkman (1984). The ruminative response to depression is clearly emotion-focused. The "healthy" response to depression was reported by Butler and Nolen-Hoeksema (1994) to be the use of distraction.

These cautionary points regarding the response styles theory are offered. Though this research is entirely valid and valuable it does not, as yet, consider long-term effects of distraction techniques, nor does it address the extent to which distraction is avoidance. These are key issues in considering the actual level of emotional wellness of an individual. That is, an individual that engages in distraction (avoidance) techniques most of the time may, indeed, not be depressed, but may also not be considered "emotionally well." The theory is, however, useful as it provides studies of coping styles associated with the maintenance of depression, and a possible coping style, distraction, that encourages emotional wellness if it is not taken to the extreme.

Suls and Fletcher (1985) considered private self-consciousness, which was defined as "...a disposition to focus on covert and internal aspects of the self-moods, emotions, and feelings, and is measured by a subscale of the Fenigstein, Scheier, and Buss Self-Consciousness Inventory" (p. 470). Suls and Fletcher (1985) asserted that people with a high capacity for private self-consciousness were better able to attend to psychological, behavioral, and physiological reactions to stress. This personality characteristic is hypothesized to make people better able to cope effectively.

At first glance this theory may seem to be a contradiction to the response style theory (Nolen-Hoeksema, 1987, 1990). These theories are similarly based on the notion of "self-focus," but differ in the productivity of this action. An over-simplification may be that, rumination is negative in focus and non-productive and private self-consciousness is positive and productive. Private self-consciousness is a broad term and rumination is discreet.

Private self-consciousness is a coping strategy in which an individual engages in a productive self-focus in order to gather information about how one is responding to stress. In this way, it is similar to the conception of the problem-focused information gathering strategy of problem resolution by Lazarus and Folkman (1984). Private self-

consciousness is broader still than this concept because it also may include emotion-focused mechanisms, as well as problem-focused coping.

The third group of theories continue to concentrate on self-focus but only in response to success and failure. Carver and Scheier (1981) offered a theory of self-regulation. The authors stated that self-awareness serves a self-regulatory purpose. This is similar to Suls and Fletcher (1985) private self-consciousness, which serves to facilitate information gathering and problem resolution. With regard to depression, Carver and Scheier (1981) theorized that negative self-focus after a negative outcome, or discrepancy, produces negative affect when the individual judges that there is little chance of changing the outcome. For example, if a person performed poorly on a job assignment, it is likely to lead to negative self-focus, which may or may not be productive. The person will introspect, and if he or she perceives no feasible resolution of the event, it will lead to negative affect. The person in the above example may not be able to do the job again, and feel stuck in his or her failure, not seeing a way to resolve the problem, which leads to negative affect.

Coping theory can be applied to the self-focus theories. A person's self-awareness, and the resulting interpretations, are subject to the same interpretational biases that have been discussed throughout this discussion. Even the example above could be interpreted so that positive affect would result. For example, the person may come to the conclusion, following self-focused attention, that he or she will take the constructive feedback from the employer and apply it to the next job task.

Greenburg and Pyszczynski (1986) also discussed, and tested, a self-regulatory perservation theory of depression. They stated that this theory was based, in part, on Carver and Scheier's (1981) theory of self-regulation. Greenburg and Pyszczynski (1986) state that:

> The consequent perseveration in self-focusing on irreducible negative discrepancy leads to intensified negative affect, self-criticism, self-blame, and the adoption of

a unique depressive self-focusing style in which the individual seeks self-focus after negative outcomes and avoids self-focus after positive outcomes. p. 1039

The major difference between Carver and Scheier (1981) and Greenburg and Pyszczynski (1986) is that Carver and Scheier (1981) stated that negative affect does not always follow a negative discrepancy, negative self-focus follows. Negative affect only results when it is perceived that there is a slim chance of negative discrepancy resolution. Greenburg and Pyszczynski (1986) stated that negative affect always results from a negative discrepancy.

Greenburg and Pyszczynski (1986) also supported that individuals who engaged in self-focus after failure, increase negative affect and decrease positive affect, increase self-criticism and decrease self-praise, make internal attribution for failures and external attribution for successes, and increases pessimism (supports Peterson et al., 1984) and decreases motivation. These tendencies together may lead to the development of depressive symptomatology. This "perseveration" is comparable to Nolen-Hoeksema's (1991) ruminative response style. They cite several studies that reportedly support the preceding suppositions (Arieti & Bemporad, 1978; Carver, Blaney, & Scheier, 1979; Coyne & Gotlib, 1983; Duval & Wicklund, 1973; Fenigstein & Levine, 1984; Ickes, Wicklund, & Rerris, 1973; Scheier & Carver, 1977; Scheier, Carver, & Gibbons, 1979)

The studies presented by Greenburg and Pyszczynski (1986) supported the notion that depressed persons are more likely than non-depressed persons to engage in self-focus after failure and that the antithesis is true: non-depressed people engage in more self-focus following success than depressed individuals. Greenburg and Pyszczynski stated that this "suggests that for the depressed person, self-focus after failure is not aversive, but self-focus after success is" (p. 1043). The author of the current paper disagrees with this conclusion. For example, if a person found self-focus following failure non-aversive then they would be content in their failure and would not be depressed. Greenburg and Pyszczynski continue with, "These findings are consistent with the idea that depressed

persons are motivated to maintain a negative self-image" (p. 1043). They cite the following studies as support of this notion (Adler, 1924; Becker, 1973; Freud, 1917/1957; Mollon & Parry, 1984). They offer this explanation:

> Depressed persons may find comfort in such a view of themselves because it offers a convenient, unassailable explanation for the negative outcomes they experience, minimizes demands for future positive outcomes, and greatly reduces the potential for disappointment when additional negative outcomes occur. p. 1043

In opposition to this point, this may indeed account for a small percentage of individuals that may present depression-like symptomatology. It seems highly unlikely that a person would choose genuine depressive symptoms to escape positive outcomes, and to give themselves an excuse for the negative outcomes they experience. Greenburg and Pyszczynski (1986) offer an additional comment "...we suggest that because investment in a positive self-image may have made it possible for the person to experience tremendous emotional devastation following some stressful life event, he or she shies away from such optimistic perspectives on the self" (p. 1043). They offer this conclusion "the depressive self-focusing style has the potential to greatly exacerbate the depressed person's negative experiences and thereby significantly contribute to the state of depression" (p. 1044). This last point seems to be both logical and supported by research. The presented reason regarding the motivation to avoid a positive outlook needs further scientific investigation. The research by Greenburg and Pyszczynski (1986) appears sound but there are questionable judgments made about the nature of depression that are not based on their presented research. Their stance on the self-regulation theory, however, was noteworthy.

Brewin (1985) offered a review of several theories of depression. He was thorough in many ways, but did not adequately consider the cyclic nature of the condition. That is, the more depressed a person becomes, the more the depression

accentuates the unhealthy behaviors that initially led to the depression. Depression, therefore, results from, but also produces, inaccurate appraisals and poor coping. He classified the models of depression into five groups: symptom, onset, vulnerability, recovery, and coping models.

The symptom model presumes that, for some people, the experience of a stressful event leads to the onset of depression, which leads to depressive attributions (internal, stable, and global). The onset model asserts that when a person experiences a stressful event, it leads to a depressive attributional style, which results in depression. The vulnerability, or diathesis-stress, model presumes that an aversive event and a depressive attributional style lead to depressive attribution, which leads to depression. It is important to note that these models require an aversive circumstance before depression develops. The last two models do not emphasize this concept. The recovery model states that the onset of depression leads to depressive attributions, which leads to the maintenance of the depression. The coping model asserts that a person using a depressive attributional style is likely to develop depression, or maintain his or her depression. Brewin (1985) offers these conclusions:

> There are good reasons to believe that level of depression influences the intensity or certainty with which depressive beliefs are held (the symptom model), but causation does not appear to be one-way. This is because attributions are able to predict recovery from or resistance to depression over long periods (the recovery/coping models), and therefore cannot be irrelevant state-specific symptoms. p. 305

Concluding Comments Regarding Depression and Coping

Several theories concerned with the origins and maintenance of depression were considered. Similarities between the theories were noted throughout the discussion. As one considers these theories at a conceptual level, rather than focusing on the concrete taxonomy, many similarities emerge. Primarily, the maladaptive, or unhealthy

assumptions people subscribe to, greatly influence the appraisal-coping process. Secondly, the use of an unproductive negative self-focus, be it on mood or performance, fosters depressive symptomatology. Interestingly, the theories only consider limited aspects of the coping process. The focus is on what a person is doing wrong, rather than providing suggestions for how to improve.

A Brief Review of the Research Concerned with Emotional Wellness

The field of Psychology has its roots in the medical model. For several decades the medical community was focused on ill-health. This seems only natural given the limited medical knowledge in the past. Psychological research and clinical practice have contributed a great deal to the knowledge base of many medical illnesses. That is, the medical community focused on the answer to the "what is it" question. This approach has been necessary in order to learn more about illnesses, to better understand infirmity, and to offer treatment.

By focusing on illness, the medical community has, at times, received a negative reputation, perhaps unfairly. In the subsequent section on wellness and coping, it is stated that information gathering is one of the most productive and stress-resisting approaches to problem solving. Medical personnel have been gathering information on illnesses in order to better understand the problem. Another step to understanding medical illness is concerned with the question "What can be done about it?". Researchers, clinicians, and people in many fields, therefore, have investigated potential treatments for various ailments. With our expanding knowledge of certain medical illnesses, people have begun to consider a third question, "How can this be prevented?". The stage of medical research and focus depends, nearly exclusively, on the illness one is considering. However, the third question, regarding prevention, has become the stage of focus for many ailments, such as high blood pressure, heart disease, and certain cancers. The increased focus on prevention has resulted in a forth area of study: lifestyles and behaviors that encourage health rather than illness. There have been numerous books

written regarding healthy diet and nutrition, healthy physical exercise, meditation, and improving brain power. The field of Psychology has followed these trends, and, at times encouraged, and even directed the research community to consider this new "wellness" approach to treatment.

One can peruse any psychological journal and encounter terms such as; "depression," "anxiety," "phobia," "hopelessness," "...disorder," "maladjustment," however, it is not as common to confront such terms as; "well-being," "happiness," "well-adjusted," "hopefulness," "peacefulness," and "emotional wellness." These conceptions of wellness are relatively novel and are gradually making their way into theoretical models and research journals.

As stated previously, much of the research in the area of coping has focused on "good" versus "bad." This is especially true when considering research regarding coping and emotional well-being. Researchers have tended to assume that a person that does not meet the criteria for a Major Depressive Episode, is emotionally well. With that frame of reference, it would make some sense to lessen the ineffective behaviors, thus making a person "well." If one views emotional wellness, however, as having limited ineffective coping behaviors and having considerable effective coping skills, then only focusing on ineffective behaviors is not enough to encourage true emotional wellness. Theoretical models of psychological wellness and research in the area of emotional wellness are reviewed in this section. It was difficult, at times, to distinguish between pure theories of emotional wellness and the more global consideration of wellness that included other aspects of human nature.

Gannon, Vaux, Rhodes, and Luchetta (1992) proposed a model of wellness that considered negative and positive affect to be on two separate axes. They based their two-domain model of wellness on Bradburn's (1969) similar presentation. These authors asserted that psychological well-being was the result of positive and negative affect domains. They viewed depression as the result of both the presence of negative affect

and the relative lack of positive affect. If one considers an apathetic individual, this person may apparently lack positive affect, but they may also lack negative affect. This person would not likely be diagnosed as experiencing a Major Depressive Episode, and the person would be labeled "non-depressed" and "well" for research and, at times, clinical purposes.

Gannon et al. (1992) assessed several psychological and physical domains: positive affect, negative affect, depression, somatic complaints, daily hassles, daily uplifts, social support appraisals, and personal attributes. One of the reported purposes for the research was to establish that depression was associated with both positive and negative affects. This hypothesis was moderately supported. They also determined that the two-factor model fit the data significantly better than the traditional one-factor model. These two findings alone are encouraging and take clinicians and researchers one step closer to unraveling the mysteries of psychological health.

It has been proposed that emotional expression consists of three aspects: positive affect; negative affect; and, control. The negative and positive affect components of emotional expression are based on the research by Bradburn (1969); Gannon, et al. (1992); Kercher (1992); and, Watson, Clark, and Tellegen (1988). These researchers support the notion of a two-factor model of well-being. That is, depression is viewed as the presence of a surplus of negative affect and the relative lack of positive affect. Wellness is viewed as the presence of positive affect and the relative lack of negative affect. This dual-factor affect component is well established in research.

Other researchers have come to similar conclusions regarding the two-domain model of psychological well-being. Kiuper and Dance (1994) presented research that focused on the relationship between dysfunctional attitudes and stress associated with social roles, as they influence emotional well-being. It should be noted that the authors have focused on the negative, and excluded the positive, by the lack of assessment of functional attitudes and strength gained from certain social roles. However, the authors

modestly considered both positive and negative affect in one of their studies. They later conclude:

> By systematically assessing these three components of well-being [positive outcome measures, negative affect, and self-esteem], and also including relevant personality variables, a more complete picture of the links between personality, role attributes, and psychological well-being may then emerge. p. 260

Ryff (1989) considered the meaning of psychological well-being, believing that the majority of the wellness research and assessment devises were not based in theory. The instruments that are typically used to assess aspects of wellness centered on constructs such as; life satisfaction, self-esteem, morale, and locus of control (Ryff, 1989). More recently, well-being has been thought to contain within its domain self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth. These constructs were operationalized by Ryff (1989) and were based on work by Wiggins (1973). Ryff (1989) studied the relationship between these components and the components measured by the traditional wellness tests (e.g., life satisfaction, self-esteem, and morale). It was found that traditional research may have a definition of wellness that is too narrow. Ryff found support for all six of her theoretically based components of emotional wellness. The proposed constructs of self-acceptance and environmental mastery were strongly correlated with traditional assessment practices. The other components (positive relations, autonomy, purpose in life, and personal growth) were found to be distinct and part of the emotional wellness domain. The presented findings suggest the need for a better understanding of emotional well-being.

Emotional self-care is also an important aspect of emotional wellness. It includes the degree of healthy behaviors (e.g., assertiveness and provision of time for oneself to enjoy and/or restore) and/or the degree of unhealthy behaviors (e.g., working too hard

and beating oneself up for a simple mistake). This concept has been included in wellness tests (e.g., the LAQ developed by the National Wellness Institute in 1983).

Other components of emotional wellness are concerned with genuiness, emotional intimacy, and emotional growth. These constructs are also common to wellness models. Mullen, Gold, Belcastro, and McDermott (1990) pose the notion of realness, termed genuiness here. They describe a "real" person as being honest. This may also be conceived of as the extent to which a person uses facades. Emotional intimacy includes the process of being emotionally genuine with another person, who in turn, reciprocates the genuiness. There is also a reciprocal sense of commitment to the other's well-being. Emotional growth has been referred to as "transcendence" in some wellness models (Chandler, Holden, & Kolander, 1992). Chanler, et al. (1992) suggest that "'Transcend' is meant to imply a 'moving beyond' in a direction of higher or broader scope..." (p.168). Archer (1987) asserts that wellness implies growth. He states, "The process and state of a quest for maximum human functioning that involves the body, mind, and spirit" (p. 311).

There is, however, not a lack of theory regarding emotional wellness. One needs only to consult a personality theory textbook. In 1933, Jung presented his views of individuation, Rogers (1961) discussed the components of the fully functioning person, Gordon Allport, in 1961, discussed psychological maturity, and Maslow (1968) proposed the conception of self-actualization. These theories, however, do not have specific research-based definitions of the constructs that specifically apply to the therapy session.

Finally, the wellness research is closely compared to some of the medical pronouncements for good health. That is, aspects of psychological functioning for wellness become all-powerful prescriptions that society believes need to be followed by everyone, all the time. Much like society's apparent worship of certain fad diets and exercises: not considering, or being given the entire picture of individual differences, life-span considerations, or gender differences.

Throughout the presentation of these models, recurring themes in the wellness research begin to emerge. The authors, however, do not offer clear, easily operationalizable definitions of their conceptions so that they may be readily used by the psychotherapist in the therapy session. This becomes problematic when considering testing the models or using them to help determine treatment goals. If a person, therefore, was to consider these theories and endeavor to create a measure of emotional wellness it would be difficult to discern which aspects of psychological functioning should be included in the formulation of such a psychometric device. This lack of clarity presents similar frustrations for the psychotherapist. Some of the major issues of wellness research have been presented. Several theories will be offered that specifically consider coping as a fundamental process of emotional wellness.

A Brief Review of the Research Concerned with Emotional Wellness and Coping

In the last two decades there have been several proposed theories that focus on healthy coping styles. People with a certain constellation of traits, many times, will be termed "stress-resistant" and considered more psychologically healthy than their "stress-prone" counterparts. This section concentrates on the most prevalent theories of stress-resistant personalities. Some of the theories to be presented have already been discussed in previous sections and, therefore, will only be referred to in order to enhance the flow of discussion. The format of discussion is simply a chronological presentation of the theories.

Rotter's (1966) locus of control has already been discussed and is referred to here to emphasize that this theory considered both healthy and unhealthy coping. That is, it was hypothesized, and moderately supported, that individuals with an internal locus of control were better equipped to cope with stress. They were more likely to choose an active form of coping, which is typically associated with more productive problem resolution.

Bandura (1978, 1982) discussed the sense of self-efficacy. He believed that a person's discerned level of effectiveness greatly influenced the way he or she responded (behaviorally, cognitively, emotionally, and physiologically) to "stressful" situations. A person's level of self-efficacy influences the situations he or she chooses to encounter, the appraisals, and the responses made.

Antonovsky (1979) discussed a constellation of coping traits that he termed "coherence." He later (1987) defined the sense of coherence as the belief that the world is: structured, predictable, and explainable (comprehensible); manageable; and, meaningful. Antonovsky suggested that the three beliefs were associated with psychological health. These beliefs affect the way people respond to (cope with) stressful situations, how they interpret the event, how they react, and how they resolve the situation.

Antonovsky (1987) devised a test to establish a person's sense of coherence. The test has three scales, reflecting his proposed components of the sense of coherence. Researchers, in 1994, investigated the sense of coherence and the assessment instrument (Flannery, Perry, Penk, & Flannery, 1994). Flannery et al. (1994) used the Sense of Coherence Scales and tested subjects for self-reported depression using the Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979), life stress using the Hassles Scale (Kanner, Coyne, Schafer, & Lazarus, 1981), locus of control using the Internal/External Locus of Control Scale (Rotter, 1966), and sociability using the Social Support Index (Wilcox, & Bickel, 1983). The authors concluded that the Sense of Coherence scales provided helpful information regarding successful coping with life stress, depression, and anxiety. In a comparison of the statistical performance of the Sense of Coherence scales with the Internal/External Locus of Control Scale and the Social Support Index, it was found that the Coherence Scales accounted for a modest, but significant, amount of the variance, while the other scales did not (Flannery et al.).

Another proposed stress-resistant personality, hardiness, was advanced by Kobasa, Maddi, and Courington (1981). The hardiness constellation consists of three characteristics: control, commitment, and challenge. "Control" is the sense that one is capable of exerting some influence over the external world. This is similar to internal locus of control (Rotter, 1966) and Antonovsky's (1979) "manageability" component of the sense of coherence. These concepts are concerned with the individual's belief that he or she can effect a meaningful alteration in the environment. The second factor considered by Kobasa et al. (1981) is commitment. This construct assumes an approach to life that encompasses a purposefulness, or meaningfulness, to life. Again, this mirrors Antonovsky's second component of meaningfulness. It is also similar to the spirituality component of wellness proposed by Witmer et al. (1992). Finally, a belief that life and the world are always changing, from a positive frame of reference, comprise the "challenge" component of the hardiness personality. Individuals with this capacity tend to view "stressful" events as challenging and approach rather than avoid potentially stressful situations.

Learned Resourcefulness (Rosenbaum, 1983) is a conceptualization of a personality that is described as a "psychological immunization." Rosenbaum (1983) described learned resourcefulness as an acquired storehouse both, of behavioral and of cognitive competencies, that function to aid the person in moderating the internal experiences of emotions and cognitions that may, if uncontrolled, interfere with adaptive problem solving. Rosenbaum (1980) developed the Self-Control Schedule (SCS) that consists of 36 items fashioned to evaluate four personality characteristics involved in the control of potentially interfering emotions and cognitions: cognitive skills; problem solving strategies; ability to delay gratification; and, a belief in one's self-efficacy.

The SCS has been used in the investigation of depression and in relation to physical health (Rosenbaum, 1990). The following study is offered to provide a validation of the SCS. Burns, Rude, Simons, Bates, and Thase (1994) found that patients

scoring high on the Self-Control Schedule (Please note that high scores indicate effective learned resourcefulness) at intake and that were more severely depressed, improved the most during the first 12 weeks of treatment with cognitive-behavioral therapy. They, however, supported the conclusion that the SCS should not be used to predict a patient's recovery potential. These results offered some support for the conception of learned resourcefulness, in that, people with this trait constellation and that are severely depressed, were more able to benefit from the approach of cognitive-behavioral therapy.

Emotional control is a common construct included in wellness models. Antonovsky's Sense of Coherence model with three primary components (manageability, comprehensibility, and meaningfulness) is an example of a typical model that eludes to the concept of emotional control. Antonovsky's (1979) concept of manageability closely resembles emotional control. The "stress-resistant" personality model, which consists of control, commitment, and challenge (Kobasa et al. 1981) is another example. Learned resourcefulness (Rosenbaum, 1983) has, in fact, self-control as its basic foundation. The concept of emotional control is well established in the research, and its inclusion in the pilot test of emotional well-being is important.

More recent research has focused on problem-solving appraisal. Self appraised problem-solving ability has been found to predict a person's response to problems. If a person, for example, judges him- or herself as efficient at problem solving, then he or she will be less likely to be adversely affected by the hassles of every-day life.

In one study by Dixon, Heppner, and Rudd (1994) problem-solving appraisal is considered along with hopelessness and suicidal ideation. The phrase 'problem-solving appraisal' is used by the authors to denote people's appraisal of their problem-solving ability. The authors hypothesized that there would be an indirect effect of appraised problem-solving ability on predicting suicidal ideation, through its association with hopelessness. They report that their study supported their prediction. They also offer

that the role of problem solving in psychological wellness may not be as direct as previously conceptualized.

Another study concerning problem-solving appraisal, conducted by Elliott and Marmarosh (1994), considered problem-solving appraisal, health complaints, and health-related expectancies. This study, and the previous study, utilized the Problem-Solving Inventory (PSI; Heppner, 1988). According to the PSI, people that appraise themselves as being effective at solving problems, have three fundamental characteristics: high confidence in problem-solving competence; ability to control emotional expression and experience (similar to learned resourcefulness); and, approach rather than avoid stressful situations (Heppner, 1988). Elliott and Marmarosh (1994) cite several studies to support the following conclusions (Baumgardner, Heppner, & Arkin, 1986; Chartrand, Rose, Elliott, Marmarosh, & Caldwell, 1993; Elliottt, Godshall, Shrout, & Witty, 1990; Heppner & Neal, 1983; Heppner, Reeder, & Larson, 1983; and, Nezu, 1985). People that appraise themselves as effective at problem solving, tend to have higher expectancies for control, make fewer self-blaming attributions, infrequently utilize irrational beliefs, and have an higher self-concept and less self-criticism. They also tend to have the following characteristics: adaptive study behaviors; healthy perspectives on study; rational decision-making techniques; and, appreciate cognitive activities.

In the study by Elliott and Marmarosh (1994), it was predicted that self-appraised problem solving ability would be directly associated with health expectancy and health complaints in a college population. Their findings support this prediction. In considering gender, they only found one statistically significant measure: women tended to report more negative perceptions about their health (during final exams) at the time of the study. The authors do not offer an interpretation for this finding.

Finally, a third study considering self-appraised problem-solving ability was provided to emphasize the importance of this area of research. In a study conducted by Elliott, Sherwin, Harkins, and Marmarosh (1995), self-appraised problem-solving ability

was investigated in relation to affective state and psychological distress. Again, the Problem-Solving Inventory (Heppner, 1988) was used to determine self-appraised problem-solving ability. The authors attempted a theoretical bridge between the PSI, where the three factors had been named post hoc, and the problem solving model of D'Zurilla and Goldfried (1971). Briefly, the problem solving model (D'Zurilla & Goldfried, 1971) breaks problem solving into five stages: problem orientation; problem definition and formulation; generation of alternatives; decision making; and, verification.

Elliott et al. (1995) continued by discussing two aspects of interpersonal problem solving: problem orientation and problem-solving skills. The latter is concerned with the five stages of problem solving. Problem orientation is the emotional, or "motivational," component of problem solving. For example, if a person has a positive orientation to problem solving, then this functions to help immunize the person against anger, depression, and anxiety. It also encourages positive feelings and self-efficacy in problem solving, decreases impulsive response styles, and encourages an approach, rather than an avoidance, response to solving problems (D'Zurilla & Nezu, 1990; D'Zurilla & Sheedy, 1991; Nezu & D'Zurilla, 1989; Elliott, et al., (1995). Elliott et al. found that the problem solving orientation was approximated by the problem-solving confidence and the personal control factors of the PSI. It was shown that a positive orientation, tested by the PSI, was significantly predictive of a more positive daily mood, a better mood state before an exam, less negative mood states prior to examinations, and less negative mood states while recalling stressful situations.

This research was valuable for, at least, three reasons. It has given some theoretical foundation to the PSI. It has, also, supported the recurring theme that people that have both better problem-solving skills and a positive outlook are less likely to be depressed, anxious, or angry. It, also, supported the dual-axis model of emotional well-being by considering both positive and negative aspects of emotional well-being.

Research presented by Suls and Fletcher (1985) was already presented in the section concerned with coping. It is repeated here because their notion of introspection also relates to emotional wellness. They considered a process of introspection that they termed "private self-consciousness." It is defined as, "a disposition to focus on covert and internal aspects of the self-moods, emotions, and feelings, and is measured by a subscale of the Fenigstein, Scheier, and Buss Self-Consciousness Inventory [1975]" (p. 470). These researchers, therefore, supported the notion that people who used the self-attention style of coping were more stress resistant than those who had not practiced self-focusing techniques.

Several studies that considered coping and emotional wellness were presented. It is evident from the review that researchers approach coping skills associated with emotional well-being from many different perspectives. The different perspectives regarding coping and emotional well-being are of primary interest for the present explorative study. These differences are discussed more thoroughly in the concluding comments of the literature review.

A Review of the Research Concerned with Aspects of Human Nature that are Related to Emotional Well-Being

The purpose of this portion of the literature review is to establish the aspects of human nature that are typically referred to, and used, both in wellness models and wellness tests. This helped determine the aspects of human nature that were included in this explorative study concerned with how these aspects of human nature may impact emotional well-being. It has, also, served to establish the specific content of each aspect of human nature that was included in the test designed for this explorative study.

It seems appropriate to consider previously proposed theories of wellness, searching for one that may be adaptable for the purposes of this explorative study. There are many theories of wellness that consider several aspects of human nature, but the prototype theory appears to contain some variation of six components: emotional;

physical; intellectual; occupational; social; and, spiritual health (Hettler, 1984). Many, if not most, of these theories seem very comprehensive and based in systematic inquiry and clinical experience. The problem, however, is that the degree of interrelationship between the aspects of human nature is not typically studied. Again, it is of particular interest to begin exploring the impact the other aspects of human nature have on emotional well-being. Many theories are very interesting and useful but they are not formulated in a manner that is easily testable for the purposes of this explorative study.

A holistic model of wellness was presented by Witmer and Sweeney (1992). The model is clearly presented, but the concepts are not easily testable. Nonetheless, the model deserved to be presented in this discussion. The theory presents a life span perspective consisting of five life tasks: spirituality, self-regulation, work, friendship, and love. Included in these life tasks are several proposed dimensions of a healthy lifestyle. Each life task will be reviewed separately with consideration of the proposed healthy aspects.

Spirituality consisted of two dimensions. "Oneness and the inner life" refers to an individual's philosophy that he or she is part of a whole, in this case, part of the universe. This also refers to the striving for inner peace, a sense of completeness, and unity with society and the world. The second component of Spirituality is "purposiveness, optimism, and values." This included notions of the meaning of life, hope for the future, and sound values (more specific definition was not provided). The authors considered spiritual values to be similar to morals that contribute to health of the 'whole,' the self, others, and the universe.

Self-regulation was composed of several dimensions: sense of worth; sense of control; sense of humor; realistic beliefs; spontaneity and emotional responsiveness; intellectual stimulation; problem solving, and creativity; and, physical fitness and health habits. Sense of worth and sense of control in combination comprise self-esteem. There is considerable overlap with the hardy personality proposed by Kobasa (1979). Kobasa

stated that control, challenge, and commitment compose the stress-resistant personality, hardiness. Witmer et al. (1992) also proposed the importance of a sense of humor, which is a person's capacity to react to humor with amusement and provide humor for others. They stated that in order for it to be healthy it must be consistent with a person's spiritual morals, The concept of spontaneity is self-explanatory. Emotional responsiveness refers to people that react emotionally without unnecessary guard, is unlikely to keep emotions tightly restrained, and more likely to be spontaneous in their actions and reactions. Intellectual stimulation, problem solving, and creativity are also self-explanatory. The concept of problem solving has been discussed in the research concerned with self-appraised problem solving ability and problem appraisal which will be discussed in detail in the succeeding section (Dixon, Heppner, & Rudd, 1994; Elliottt & Marmarosh, 1994; Elliottt, Sherwin, Harkins, & Marmarosh, 1995; and, Lazarus & Folkman, 1984). Physical fitness and health habits include: eating regularly, having breakfast, moderate exercise, adequate sleep, no smoking, moderate weight, and moderate or no alcohol consumption.

The third life task proposed by Witmer, et al. (1992) was concerned with work. Work was broadly defined and considers all that people do to preserve themselves and others. The authors supported the notion that work has psychological, social, and economic benefits. It is apparent that these concepts overlap to a large extent. The benefits of work are related to self-esteem, purpose in life, and more.

Finally, the last two life tasks were friendship and love. Friendship consisted of an interest in social interaction and a sense of connectedness in these interactions. It also referred to the maintenance of a healthy social network, healthy interpersonal relationships, and positive physical health. The life task of love centers on the capacity for intimacy, trust, self-disclosure, cooperativity, and commitment (Witmer et al., 1992).

A multidimensional systems model of wellness proposed by Crose, Nicholas, Gobble, and Frank (1992) follows the prototype version consisting of six dimensions of

human nature. For assessment purposes, however, they offer several subcategories. Each of the aspects of human nature that they chose are described. This model is offered both, as a comparison for the Witmer et al. (1992) model, and as a source of more information for the test for the current explorative study. Crose et al. (1992) propose a model consisting of the following aspects of human nature: physical health and wellness; emotional health and wellness; intellectual health and wellness; occupational health and wellness; and, spiritual health and wellness.

The physical health and wellness dimension consists of obtaining an indication of the client's medical history, medications being used at the time of assessment, reproductive health history, body image, exercise and eating behaviors, and attitudes toward physical self-care. This description of physical health provided some of the content that was used in the test that was developed for this explorative investigation of emotional well-being.

The emotional health and wellness section of the multidimensional modal of wellness proposed by Crose et al. (1992) is composed of psychiatric history/medications, coping style/pattern, self-awareness/self-image, and attitudes toward emotional expression/self-disclosure. Crose et al. suggested that this information be obtained either through clinical interview or with the use of tests (however suggestions for tests were not provided).

The social health and wellness section aspires to assess the following: a history of significant relationships; the nature of the social network; relationship patterns; attitudes toward developing significant relationships; and, attitudes regarding receiving help from others. The social health and emotional health sections of this model provided content that was included in the test designed for the explorative study of emotional well-being.

The intellectual health and wellness section of the model proposed by Crose et al. (1992) consists of considering a client's educational history, mental status, cognitive style and flexibility, and attitudes toward learning. The occupational health and wellness

section consists of assessing: work history; balancing work and pleasure; vocational goals; and, attitudes toward working and leisure. The descriptions of intellectual health and occupational health provide useful information but are difficult to assess with uniformity.

Crose et al. (1992) suggested that a client's spiritual health and wellness should be assessed by considering the following: religious/spiritual history; life satisfaction; purpose and meaning in life; and, attitudes toward transpersonal aspects of living. This framework was used for the test developed for this explorative study of emotional well-being. The content of the spiritual health section provided by Crose et al. was supplemented substantially by consulting other research. This will be discussed in detail in a later section of this dissertation.

The Crose et al. (1992) and Witmer et al. (1992) models represent the current state of wellness research. The determination of which aspects of human nature may impact emotional well-being the most, is difficult to ascertain. Upon consulting several wellness instruments one begins to notice several recurring themes and many important differences. The Wellness Inventory (WI; Travis, 1981) contains 120 items contributing to 12 scales. These scales are titled: self-responsibility and love, breathing, sensing, eating, moving, feeling, thinking, playing and working, communicating, sex, finding meaning, and transcending. The Life Assessment Questionnaire--Wellness Assessment Questionnaire (LAQ; National Wellness Institute, 1983) consists of 100 questions that compose 11 dimensions: physical fitness, physical nutritional, physical self-care, drug use, driving safety, social environmental, emotional awareness, emotional management, intellectual, occupational, and spiritual. Finally, the Lifestyle Coping Inventory (LCI; Hinds, 1983) consists of 142 questions that constitute seven aspects of wellness: coping style actions, nutritional actions, physical care actions, cognitive and emotional actions, low-risk actions, environmental actions, and social support actions. The apparent

components of wellness, as inferred by the scale taxonomy, show the similarities but also illustrates the lack of consistency and conceptual overlap.

In a review of the psychometric properties of these instruments by Palombi (1992) it was concluded that the "WI, LAQ, and LCI are measuring a unidimensional construct called 'wellness'." (p. 225), unfortunately issues of multicollinearity were not addressed. Palombi also concluded that all three tests were psychometrically competent when measuring a college-student population. Palombi's research (1992), however, provides encouraging results, although somewhat confusing. That is, these tests are reportedly measuring the same domain, however, are based on different dimensions and conceptions of wellness.

Meyers (1992) stated that even though the "zeitgeist" in wellness research is the six-factor model, it seems that most wellness models can be summarized into mind, body, and spirit. The numerous aspects of human nature that are included in the reviewed wellness tests are somewhat ambiguous and, therefore, difficult to define. If one considers the prototype model of wellness which consists of physical health, emotional health, spiritual health, occupational health, intellectual health, and social health, then one begins to notice overlap in the six factors. A three factor model, however, may be too limiting. The model used for this study needed to be as applicable to the therapy session as possible.

It is relatively undebatable that a wellness model should consider physical well-being and spiritual well-being. These two constructs seem to appear in every wellness model. The confusion begins when considering what to include in the emotional well-being factor. The prototype model separates emotional health from social health. The three factor model of wellness includes the concept of mind, presumably to encompass emotional well-being, social well-being, intellectual well-being, and occupational well-being. Both views seem difficult to apply to the therapy session. In reference to the six-factor model of wellness, it is difficult to separate emotional well-being from

interpersonal health, as they are so closely linked in all aspects of day to day life. As well, the three factor model may consolidate the "mind" component too much. This is especially true considering the purpose of this study.

Recall that the secondary purpose of this study was to determine the impact certain aspects of human nature have on emotional well-being. Therefore, for the purposes of this study, a four factor model was used. The four aspects of human nature to be studied are: physical health, spiritual health, intellectual health, and emotional well-being. Therefore, the secondary purpose of this explorative study was to begin investigating the impact that a person's spiritual, intellectual, and physical health may have on emotional well-being. In order to better develop the content of each factor a brief review of the research is offered.

Spiritual health. The construct, spiritual wellness, is one of the chosen aspects of human nature that will be considered in relation to emotional well-being. Every psychotherapist has heard from their clients some variation of the following theme: "There just doesn't seem to be a reason to try;" "I don't see the purpose in life;" "I have the perfect life, nice house, relatively happy marriage, children, good job, but something is missing;" and, "I need to get a sense of the big picture." The concept of spirituality, however, has been difficult both, to define and to measure.

Witmer et al. (1992) states that spirituality "assumes certain life-enhancing beliefs about human dignity, human rights, and reverence for life" (p. 141). This definition lacks clarity, although provides some pertinent information. Attempting to be more precise, Chandler et al. (1992) defined the word "spiritual" as "Pertaining to the innate capacity to, and tendency to seek to, transcend one's current locus of centricity, which transcendence involves increased knowledge and love" (p. 169). The concepts of knowledge and love were elaborated by Chandler et al. (1992) who stated that "Greater knowledge involves conceptualization that is increasingly inclusive and focused on

commonality and unity, and decreasingly exclusive and focused on difference and duality" (p. 169). They also offered the following definition.

> "Greater capacity to love" is meant to imply the paradoxical combination of benevolent acceptance of what is, and a motivation to bring about change that results in the greater good. Together with greater knowledge, this implies an evolving sense of life purpose with its increasingly comprehensive and constructive systems of ethics and values. p. 169

It has been shown that people who pray/meditate or spiritually reflect regularly are more likely to score high on wellness measures (Paloma & Pendleton, 1991). Therefore, frequency of prayer, meditation, and personal reflection are important aspects of spirituality. This aspect of spirituality may also include all time spent in worship, perhaps, including frequency of public worship or group meetings for the purposes of worship.

Another aspect of spirituality to consider is maturity, which is referred to by Witmer et al. (1992) and Crose et al. (1992). This aspect may be expressed in a person's spiritual genuiness, and include having relationships with people with similar and dissimilar spiritual maturities. The underlying assumption is that spiritually mature individuals both develop close associations with people that are equally mature and are not threatened by people that do not subscribe to their belief system. A drive to increase ones' understanding of spirituality is also an indication of spiritual maturity and may be expressed as a pursuit for purpose in life and meaningfulness of life. Similar concepts were proposed by Antonovsky (1979), "meaningfulness," and "commitment" by Kobasa, et al. (1981). These concepts contain existential qualities.

Physical health. Recall that each of these dimensions of human nature are assessed using a self report test. It would be interesting to obtain a thorough measure of physical well-being, but for the purposes of this study the measures will consider how a person takes care of themselves. The concept of physical self-care is common to

wellness research (Travis, 1981; Hind, 1983). The concept refers to the presence or absence of several behaviors concerned with: nutrition; exercise; weight; personal safety; smoking; unsafe drug use; and, unsafe risk-taking.

Intellectual health. Again, it would be interesting to obtain cognitive testing, but was beyond the purposes of this study. Rather, the intent was to obtain an understanding of the potential impact intellectual health may have on emotional well-being. From the literature review, it seems important to consider productive behaviors that are designed to enhance one's knowledge. This may include actively learning, seeking new interests, watching the news, or procrastinating and wasting time. It is also of interest to obtain an indication of satisfaction and commitment to work.

Section Summary

This section has provided a review of the literature concerned with various aspects of human nature that impact wellness. The reader was provided with current conceptions of wellness, by a consideration of pertinent models of wellness. For the purposes of this explorative study, physical, intellectual, and spiritual health were chosen to be the aspects of human nature to be investigated against emotional well-being. The reasons for choosing those three aspects of human nature were also presented. Finally, each aspect of human nature was described in terms of how they apply to this explorative study. This section was focused on the secondary purpose of this study.

Overall Summary

The literature review has presented many theories and concepts. The reader has been lead through the evolution of theories of emotion, to theories of stress, to theories of coping. These latter theories then narrowed in focus to consider depression and emotional wellness. A review concerning the aspects of human nature that are typically associated with emotional well-being was also provided. The similarities and differences among the theories were discussed when judged to be appropriate. Research has been offered and, at times, critically reviewed. There were two goals of the introduction, one

was to provide a logical presentation and summary of the research concerned with coping processes as related to depression and emotional wellness, and the other was to provide a background of the research that considers a more global view of human nature.

Summary of Emotional Well-Being

Recall that the primary purpose of this explorative study was to develop a therapeutically relevant theory of emotional well-being. The literature review presented current research concerned with emotional well-being and coping styles. The coping perspective was chosen because it is readily applicable to the therapy session. A theory of emotional well-being, therefore, must be based on reportable and observable areas of difficulties or competencies. Once this is accomplished, one can identify coping skills associated with each of the core components of emotional well-being. Part of the purpose for reviewing the research was to establish the components of emotional well-being to be included in the test designed for this study. As was shown in the literature review, there are several proposed components associated with emotional well-being. The goal of this study is to narrow the multitude of possibilities and identify the main contributing components of emotional well-being from a coping perspective.

The current understanding of emotional well-being was described in the introductory discussion concerned with emotional wellness and depression. The review of the literature has served to provide a background of the definitions and theories concerning the constructs, stress, coping, and well-being. It can be concluded that many of the theories focus on either depression or wellness. For example, the theories of both learned helplessness (Ambramson, et al., 1978) and of response styles (Nolen-Hoeksema, 1990) are focused on understanding the influence of certain coping styles on depression. The theories of learned resourcefulness (Rosenbaum, 1983) and the sense of coherence (Antonovsky, 1979), however, are focused on inoculating someone against stress; functionally then center on wellness. There is a tendency in current research to subscribe to the belief that the absence of depression presumes wellness, but this remains arguable.

It was shown that there are many proposed components of emotional wellness. The diagnosis for depression is well established, but the concept of emotional wellness is only now getting systematic attention from researchers and clinicians.

The sections concerning coping and well-being were also helpful in obtaining a better understanding of emotional well-being. Emotional well-being encompasses a person's ability for and comfort with emotional expression, and his or her degree of emotional integration, emotional closeness, transcendence, and self-responsibility. This may include such concepts as emotional expression (positive affect, negative affect, and control), genuine versus artificial emotional expression, intimacy versus isolation, emotional growth versus regression, self-care (healthy behaviors versus unhealthy behaviors), and coping responses (avoidance versus active, and emotion- versus problem-focused). Emotional well-being also includes a person's sense of self efficacy, the sense that he or she is capable of effective problem solving, the ability to delay gratification, and viewing life as a positive challenge.

Summary of the Aspects of Human Nature Chosen for this Study

The secondary goal of this study was to explore the impact that chosen aspects of human nature have on emotional well-being. The dilemma was which aspects of human nature, apart from emotional well-being, to choose for the study. The literature review provided background information resulting in the decision to include physical, intellectual, and spiritual aspects of human nature in this explorative study. The reasons for choosing the aspects were presented. Again, the purpose is not to statistically prove that these aspects are the best ones to have chosen, but rather the purpose was to make the best choice of which aspects to study, based on the available research, in relation to emotional well-being for the purposes of this explorative study. The potential impact each of these aspects of human nature has on emotional well-being is investigated in the results section.

Concluding Comments

The emphasis for decades with regard to the medical model has been on illness, gathering information, treating, and preventing ill-health. The current goal is, at times, the absence of sickness, be it depression or anxiety. Now that affective illnesses are better understood, however, people are considering both wellness and effective and ineffective coping skills. When this "big picture" is better understood, it will provide psychotherapists with a more quantifiable goal (i.e., helping clients develop and utilize effective coping skills that cultivate emotional wellness). The primary reason for conducting this study was to further our understanding of emotional wellness and to begin to relate the information gained from the study to the therapy session.

Depression scales are given as a matter of course in clinical settings. This, obviously, provides useful information but, it does not provide information about emotional wellness. It may be more prudent, then, to refer to a more complete theory, and ultimately a test, of emotional well-being that considers an individual's coping skills repertoire for a number of aspects of emotional well-being. It is also important to consider the many people that do not meet the criteria for a Major Depressive Episode but who are not emotionally well. These "non-depressed" individuals function adequately in their day to day lives; but is there not more that they can attain?

This explorative study is based on the need to investigate emotional well-being in terms of coping skills, in order to develop a definition that is useful for the psychotherapist, provides concrete goals for therapy, and, gives the client something tangible and readily useful. Once the domain of emotional well-being is better understood, specific coping skills related to the components of emotional well-being can be better identified. With a better understanding of emotional well-being and the associated coping skills, eventually a final instrument can be developed. The instrument may, in fact, provide information about a person's level of emotional well-being and their coping skill strengths and weakness. The test ultimately may be given to a client, thus

providing the psychotherapist with an assessment of the client's coping skill proficiencies and deficiencies. Eventually, the final product will be a model of emotional well-being, a conception of the aspects of human nature that impact emotional well-being, a coping skill repertoire, and a test that could be used both in research and clinical settings.

Methods

Overview

A 273 item test was developed that consists of demographic items and four indexes (emotional, spiritual, intellectual, and physical). The primary goal was to identify several core aspects of emotional well-being from a coping perspective. The secondary goal was to explore the relationship that spiritual, intellectual, and physical health have on emotional health. These aspects were chosen based on a review of related research which was presented in the introduction.

Participants

Subjects were obtained from three states throughout the United States (Nebraska, Montana, and Idaho) with 133 males and 237 females serving as participants, for a total of 370. Age was assessed through age-ranges. The number of subjects per group is in parentheses: 17-27 (90), 28-38 (90); 39-49 (73); 50-60 (73); 61-71 (34); and 72+ (10). Subjects were mainly Caucasian (357), with the following breakdown of other races: African-American (5); Native American/First Nations (3); Asian (3); Other (1), and one missing entry. The subjects were predominantly middle-class (154), with the following breakdown: poverty level (15); low income level (35); lower-middle (77); upper-middle (72); and upper-level (14), with three missing entries. Subjects were treated in accordance with the "Ethical Principles of Psychologists and Code of Conduct" (American Psychological Association, 1992). All subjects were given an informed consent form (see Appendix A).

Instrument

The Well-Being Pilot Test (WBPT) was designed specifically for the purposes of this study. There were several reasons for the development of the WBPT. The literature review provided numerous components of emotional well-being that lend themselves to being investigated further. These research-based components have been included in the WBPT in order to identify the components that are most strongly related to emotional well-being. Another purpose for the WBPT, which is related to the first, was to investigate the research on coping skills and emotional well-being by including the propositions regarding coping and emotional well-being obtained from the literature review. The third purpose for the WBPT, was to investigate the impact that physical health, spiritual health, and intellectual health, have on emotional well-being. The literature review provided the content to be used for each index.

The statements were developed so that a response indicated either a "well" or an "unwell" belief or behavior. More specifically, the subject was instructed to respond by marking either true or false to each item. Please note that "well" responses were randomized so that "well" was sometimes denoted by a false response and sometimes by a true response.

The author of this dissertation developed a key for the WBPT which indicated the "well" answers and the category to which each item belonged (i.e., physical, emotional, intellectual, and spiritual). Two separate judges were obtained to also develop separate keys for the WBPT. The test developer desired judges that were naive to psychological research, as an advanced knowledge in this area may bias their decisions concerning wellness depending on the school of psychotherapy to which they subscribed. The judges were, therefore, naive to formal psychology but had university educations, had no history of serious depression, and were judged by the test developer to be psychologically well. The judges were respected members of a community known to have good personal relations and seem to handle stress effectively and efficiently. Each of the two judges

were asked both, to develop a key for the WBPT that reflected the well answer for each item, and to categorize the items into the four aspects of wellness that were included in the WBPT. For the latter task, each judge was only provided with the index titles, for example, emotional well-being (depression through emotional wellness), physical health, intellectual health, and spiritual health.

All three keys (the test developer's and the two judges') were compared, and only those items which all three judges agreed upon were accepted for the final test (see Appendix B). That is, all three judges had to agree on the "well" answer in order for the item to be included in the WBPT. The category the item belonged to was determined by two out of three judges agreeing on the designated category.

The final test is composed of 273 items (Appendix B). The items consist of the aspects of human nature already discussed: emotional; spiritual; physical; and, intellectual health. There are also seven items that establish demographic information. The statements were randomized using a random number generator.

The final item contents of each aspect of human nature included in the WBPT are presented to clarify their composition. The Intellectual Index consisted of items concerned with looking up words in a dictionary, enjoying work, watching the news regularly, reading books consistently, reading an informative magazine regularly, having intellectual discussions with others, having a desire to learn, and having the opinion that one is good a handling intellectual problems (i.e., budgeting money and managing time). The Physical Index included items that emphasized physical self-care, such as healthy weight, limiting fat in one's diet, limiting caffeine consumption, wearing seat belts, wearing helmets while riding bicycles, and limiting use of alcohol and illicit drugs. The Spiritual Index consisted of items concerned with being open about one's spiritual beliefs, meeting with others and discussing spiritual matters, regular church attendance, believing there is purpose in life, centering one's life on a higher power, and engaging in prayer/meditation regularly (daily to weekly).

Recall that the phrase 'emotional well-being' refers to the continuum of emotional health, from depression to emotional wellness. Items were, therefore, designed to represent this continuum and were based on the literature review. The final item content consisted of statements concerned with feelings of hopelessness, guilt, and wanting to die. As well as, items concerned with a commitment to life, levels of stress, comfort with one's emotions, ability to comfortably interact with others, degree of intimacy versus isolation, degree of self-criticism, effective conflict resolution, sense of self-esteem, and level of enjoyment.

As emotional well-being refers to a continuum of emotional health, from unhealthy to healthy, it is logical to assume that depression represents unhealthy emotionality. A depression index was created, therefore, for two reasons. First, it provided a way to determine that the "well" answers were different than the "unwell" answers. The assumption being that if the Depression Index was highly negatively correlated with the emotional Wellness Index it would provide some support that the Depression Index and the Wellness Index represent opposing aspects of emotional well-being. The second reason for developing the indexes was to provide an indication of how certain coping skills affect both depression and wellness. Theoretically, a coping skill or belief should affect both ends of the emotional well-being spectrum in opposite, but relatively equal, manners. Therefore, dividing the emotional well-being scale into depression and emotional wellness, provides a checks and balances for this exploration. The items included in the index were taken from the DSM-IV diagnostic criteria for Major Depressive Episode (see Appendix D for a complete list of the items included in the Depression Index).

Procedure

Subjects in Nebraska were obtained through a university psychology subject pool. The students were allotted credits for participation in the study. Subjects were also obtained in a medical clinic waiting room. The tests were placed in the waiting room for

people to take if they desired to participate. A sign was placed on the wall above the tests that asked for volunteers for a study concerning wellness. It also stated that the results were confidential and that the tests would be collected daily to ensure confidentiality. All participants were provided a manila envelope in which to seal the test and informed consent. Each envelope was placed in a box at the nurse's station to protect confidentiality. The researcher picked up the tests daily.

Subjects in Montana were obtained in a shopping mall, an airport, and door-to-door in neighborhoods easily accessible by the data collectors. Again, each person was introduced to the study with a brief explanation stating that the test was designed to obtain a better understanding of wellness. It was also emphasized that the volunteer's responses would be combined with hundreds of other volunteers' responses, in order to determine the patterns of wellness. As well, each volunteer was told about confidentiality and was provided a test, an informed consent, and manila envelope. All subjects were instructed to seal the test and consent form in the envelope and to phone the test collector when the task was completed, or if they had decided not to complete the test. Data from Idaho subjects were collected in the same manner.

Due to limited financial resources, this manner of sample collection was all that was possible. It should be noted that the rate of rejection by participants was not recorded due to the method of sample collection. The sample may, therefore, be biased toward those people that have an interest in wellness and emotional health. The method in which subjects were collected, therefore, did not closely follow standard randomized sample collection procedure. These two factors may have resulted in a biased test population.

Results

There were two primary purposes for conducting this research. The primary reason for this explorative study was to develop a theory of emotional well-being that is readily applicable to the psychotherapy session. The relevant research was reviewed and

all possible pertinent concepts were included in the WBPT in order to identify which of them best described the notion of emotional well-being. Included in this inquiry, were the hypotheses of other researchers regarding behavior patterns and beliefs thought to be associated with emotional well-being. Several of their hypotheses were investigated in order to determine whether the coping skill patterns were associated with emotional well-being. A thorough exploration of all the notions provided by these researchers is beyond the scope of this study because several of the theorists have their own tests to determine a subject's level of a certain aspect of emotional well-being. For example, Antonovsky (1979) has the Sense of Coherence Scales to determine an individual's level of sense of coherence. Therefore, the primary points of each proposition offered by several researchers were tested using the WBPT. The intent here is not to prove or disprove these notions, rather it is to explore their possible relationship to the identified core areas of emotional well-being. This serves to broaden the understanding of coping skills in relation to emotional well-being.

The secondary purpose of this explorative study was to obtain a better understanding of the magnitude that other aspects of human nature impact emotional well-being. The literature review provided information that resulted in focusing on spiritual, intellectual, and physical health dimensions as they relate to emotional well-being. This provides useful information for the psychotherapist, as well as, medical practitioners and spiritual leaders.

The results section begins with an examination of the indexes of the WBPT which are: emotional health (wellness and depression); spiritual health; physical health; and, intellectual health. As the emotional well-being component was of primary interest, it was more thoroughly explored and both, a depression and a wellness index were developed. The emotional health section is, therefore, divided into two indexes: a depression index and an emotional wellness index that do not share any items. The depression index is scored so that higher numbers indicate more answers that may reflect

depression. The wellness index, and all other indexes, are scored so that higher numbers reflect higher levels of wellness. The emotional wellness index was of particular interest. A discussion of the development of the index is provided. A brief examination of emotional well-being as it related to age is offered. Subsequently, the impact that spiritual, intellectual, and physical health have on emotional well-being is explored. An examination of several of the reviewed hypotheses concerning coping skills and emotional well-being is also offered.

Explanation of the Emotional Well-Being Component of the WBPT

Recall that the emotional wellness index was taken only from the items that belonged to the emotional well-being section, initially composed of 174 items excluding the items designed to represent the DSM-IV diagnosis of depression. The Emotional Wellness Index (WI) was developed by computing the total number of "well" responses, where 0 represented unwell and 1 represented a well response, from the emotional well-being section of the WBPT. The result was a total score for emotional well-being. Item-total point-biserial correlations were then calculated to establish the strength of the relationship of each item with the total. Recall that the emotional well-being component of the WBPT included a plethora of concepts taken from a multitude of research articles that had very different views of emotional well-being. Substantial variability would, therefore, be expected. Items, therefore, were accepted for the emotional wellness index if the point-biserial correlations were above .45.

The final item content of the emotional wellness index, which consists of the items with an r_{pb} equal to or greater than .45, was associated with emotional stability, close interpersonal relationships, comfort with one's self, low levels of distress, ability to relax, lack of consistent fear and anxiety, clear thought process, and feelings of emotional growth (See Appendix C for a complete list of the items included in the emotional wellness index). This process served to establish the core elements of emotional well-being which are elaborated in the discussion section of this paper. The other indexes

(i.e., Spiritual, Physical, and Intellectual) were derived simply by obtaining the sum of the well responses, coded as 1s, for each of the scales.

Indications of internal consistency of the WBPT were addressed using the reliability coefficient, which was .94. Split-half reliability also showed good consistency with a .88 correlation between the forms, and a Guttman split-half of .93. The WBPT was, therefore, judged to have at least adequate internal consistency and likely measuring the contruct of overall subjective health.

Descriptive Statistics of the Indexes of the WBPT

Table 1 presents descriptive statistics concerning all of the indexes associated with the WBPT. Assuming that the wellness and the depression indexes represent opposite ends of the emotional well-being continuum, they should be significantly negatively correlated. Recall that the indexes do not share any items. The Pearson product-moment correlation supported this supposition, $r(369) = -.77$, $p < .001$.

Table 1

Descriptive Statistics of the Indexes of the WBPT

	Descriptive Statistics					
Variable	M	K	SD	Kurtosis	Skewness	Range
Depression	1.77	11	2.22	2.31	1.61	10
Wellness	17.09	21	4.93	1.32	-1.34	21
Spiritual	21.29	33	4.62	-.59	-.10	22
Physical	27.73	33	4.13	3.69	-1.29	31
Intellectual	11.02	13	2.00	2.73	-1.42	13

Note. K represents the number of items composing the index.

Emotional Well-Being Across the Age Span

The distribution of emotional wellness and depression over the obtained age range was also of interest. The results tend to support the current notions that both depression decreases with age, and that wellness increases with age, with a decline after age 72. Table 2 presents the means and standard deviations (in parentheses) for emotional wellness and depression scores over the age ranges.

Table 2

Means and standard deviations of Wellness and Depressed Indexes for various age-ranges

	Age-Range					
Index	17-27	28-38	39-49	50-60	61-71	72+
Dep	2.28(2.4)	1.61(2.1)	1.93(2.41)	1.32(1.93)	1.09(1.76)	3.1(2.1)
Well	15.3(5.3)	17.1(4.8)	16.6(5.4)	18.6(4.0)	19.8(1.09)	16.8(4.5)

Note. Dep = depression index, Well = wellness index, standard deviations are in parentheses.

Exploration of the Relationship of the Physical, Intellectual, Spiritual, Emotional Wellness, and Depression Indexes

The interrelationship of the indexes was assessed using a Pearson product-moment correlation matrix. Table 3 describes the degree of relationship between each variable. A factor analysis is presented in Appendix E.

Section Summary

The WBPT was developed for two primary reasons: to help establish several core areas of emotional well-being and to begin exploring the relationship of other important aspects of human nature (spiritual health, intellectual health, and physical self-care) with emotional well-being. The core aspects of emotional well-being were identified with the development of the wellness index, as mentioned previously. This will be explained

further in the discussion section. The relationship between spiritual, physical, intellectual, and emotional health was also explored using simple correlations. This provides an indication of the degree of relatedness these aspects of human nature share.

The WBPT was also designed to provide some indication about the coping skills that are associated with depression or emotional wellness. In the remainder of the results section, several hypotheses offered by other researchers will be explored. Again, this exploration is not meant to prove or disprove their notions. The goal is just to provide information regarding coping skills and emotional well-being.

Table 3

Correlation matrix for the Spiritual, Physical, Intellectual, Emotional Wellness, and Depression Indexes

	Variable				
Variable	Spiritual	Physical	Intellectual	Wellness	Depression
Spiritual	1.00	.33	.27	.25	-.23
Physical		1.00	.44	.41	-.43
Intellectual			1.00	.44	-.42
Wellness				1.00	-.77

Note. All correlations were significant, $p < .001$.

Examination of Butler and Nolen-Hoeksema's Hypotheses

The first hypothesis to be considered was that women are more likely to be depressed than men. This is based on the idea that women tend to use an ineffective coping style in which they cope with depression by focusing on the potential cause of their mood and that men use the more effective coping technique of distraction when they are feeling depressed (Butler & Nolen-Hoeksema, 1994). Two items from the

WBPT were utilized to indicate whether or not a person used these techniques. Both items are provided, 'When I am down-in-the-dumps I focus on my mood and the potential cause of my mood and not on solutions to the problem,' and 'When I am down-in-the-dumps I try to distract myself (keep busy, think about something else, etc.).' Please notice that these skills may not be mutually exclusive. The coping skills have been termed "brooding" and "distraction."

Subjects were divided first by gender and then into brooders and non-brooders. Their scores on the wellness and depression indexes were of importance because this provided the indication of the relative emotional wellness associated with brooding. The means and standard deviations of their index scores are provided in Table 4. Table 5 presents the same information for distraction.

Table 4

Means and standard deviations of the Wellness and Depression Indexes by brooding and gender

	Male Brooders (n = 32)		Male Non-brooders (n = 101)		Female Brooders (n = 72)		Female Non-brooders (n = 163)	
Index	M	SD	M	SD	M	SD	M	SD
Well	13.9	6.40	18.9	3.4	13.2	5.58	18.4	3.47
Dep	3.41	3.46	1.11	1.6	2.92	2.44	1.31	1.64

Note. Well = Wellness Index, Dep = Depression Index.

A 2 (gender) X 2 (brooding) X 2 (distraction) MANOVA was performed on the wellness and depression indexes. Results of the MANOVA revealed a significant effect for brooding, $F(2, 358) = 36.89$, $p < .001$, Wilk's criterion = .83. The univariate analysis showed significance for both wellness, $F(1, 359) = 73.28$, $p < .001$, and depression, $F(1, 359) = 44.96$, $p < .001$. Results revealed a nonsignificant effect for distraction, $F(2,359)$

= 2.45, p = .09, Wilk's criterion = .99. Univariate analysis showed significance for emotional wellness, F(1,359) = 4.75, p = .03, and no significance for depression, F(1,359) = 3.37, p = .07.

Table 5

Means and standard deviations of the Wellness and Depression Indexes by distraction and gender

	Male Distracters (n = 98)		Male Non-Distracters (n = 35)		Female Distracters (n = 72)		Female Non-Distracters (n = 163)	
Index	M	SD	M	SD	M	SD	M	SD
Well	17.5	4.68	18.3	5.12	17.4	4.25	14.4	6.39
Dep	1.79	2.40	1.31	2.37	1.53	1.79	2.85	2.65

Note. Well = Wellness Index, Dep = Depression Index.

Two interactions, however, approached significance. Brooding and gender for depression approached significance but were non-significant, p = .083. These results indicate, perhaps, only a trend that women who brood are more likely to be more depressed than men that brood. Interestingly, the use of distraction techniques seemed to make little difference for men regarding their emotional well-being. With women, however, the trend, although insignificant may be that those who do not use this technique are more depressed than those that engage in it, p = .09. Again, these results only approached significance, that trends, however, were notable.

Examination of Kobasa's Hypothesis

Kobasa (1979) developed several constructs associated with "hardiness," including control, commitment, and challenge. Three test items were used to measure these factors (i.e., life is manageable, life has meaning, and the belief that they have to fight for things in life, respectively). These items were chosen by the test developer to

best represent the major concepts of the hardy personality. The choice of these items was solely based on conceptual similarity. When considering the 'challenge' construct, it was assumed that people that believe they have to fight for things in life, do not view the world as an interesting challenge. It was the opinion of the test developer that these items closely represented the major constructs of Kobasa's hardy personality.

The three items were entered into a 2 X 2 X 2 MANOVA with the dependent variables being the depression and wellness indexes. Results indicated that each coping style, or belief, was found to be significant and the interactions were not significant. All coping styles were significant, $p < .001$. Specifically, the challenge item had the following results, $F(2, 355) = 22.66$, Wilk's lambda = .89, the commitment item evidenced the following, $F(2,355) = 14.09$, Wilk's criterion = .93, and the control item, $F(2,355) = 9.53$, Wilk's lambda = .95. Univariate tests revealed that all beliefs were significant ($p < .05$) for both wellness and depression in all cases. These results support the idea that people who have a sense that they have some control in life, have some commitment to life, and find it challenging are more likely to be emotionally well.

Examination of Antonovsky's Hypothesis

Antonovsky (1979) proposed that a "sense of coherence" is composed of the belief that the world is comprehensible (i.e., structured, explainable, and predictable), that life has meaning, and that life is manageable. Please note the similarities between Antonovsky's "coherence" and Kobasa's "hardiness." Three items from the WBPT were used to represent comprehensibility, meaning, and manageability. Each test item is presented, 'All in all, I believe that the world is structured, predictable, and explainable (comprehensible)', 'I believe life has meaning,' and 'Life is not manageable,' respectfully. These items were chosen by the test developer based on conceptual similarities. These beliefs were entered into a 2 X 2 X 2 MANOVA with the wellness and depression indexes serving as the dependent variables. Results indicated that one of the interactions was significant, manageability and comprehensibility, $F(2, 354) = 3.94$, $p < .05$, Wilk's

criterion = .98. All other interactions were not significant. All individual beliefs were significant: comprehensibility, $F(2, 354) = 4.98$, $p < .05$; manageability $F(2,354) = 3.81$, $p < .05$; and meaningfulness, $F(2, 354)$, $p < .05$. The univariate analyses showed the beliefs were significant for both depression and wellness ($p < .05$) in all cases.

Examination of Rosenbaum's Hypothesis

Rosenbaum (1983) proposed "learned resourcefulness," which is a construct concerned with inoculating people against the potentially destructive side of stress. Learned Resourcefulness includes a sense of self-efficacy, good problem solving skills, cognitive skills, and the ability to delay gratification. Four items from the WBPT were chosen to represent these traits. The items are provided in the order listed above: 'Life is not manageable'; 'I am not good at dealing with emotional problems (confrontation, disagreements, etc.)'; 'When I have a problem I usually have the ability to control my thoughts and emotions so that I can resolve the situation is the best manner'; and, 'If there is nothing that I can do about a problem at the time, I don't worry about it. I put it out of my mind as best I can and get on with other things and only think about it when something can be done.'

These items were entered into a 2 X 2 X 2 X 2 MANOVA with the wellness and depression indexes as dependent variables. Results showed that the interaction between self-efficacy and problem-solving skill was significant, $F(2,339) = 6.28$, $p < .01$, Wilk's lambda = .96. Univariate analysis showed significance for only the wellness index, $F(1, 340) = 9.09$, $p < .01$. All other interactions were not significant. Each construct (self-efficacy, problem solving, delayed gratification, and cognitive skill) was found to be significant $p < .01$, $F(2, 339) = 12.74$, Wilk's = .93; $F(2, 339) = 14.43$, Wilk's = .92; $F(2,339) = 5.53$, Wilk's = .97; and, $F(2, 339) = 15.60$, Wilk's = .99, respectively. This supports the assumption that these constructs are likely contributing to a person's emotional well-being.

Examination of Seligman's Hypothesis

The notion of learned helplessness with regards to depression asserts that people who are more likely to become depressed are also more likely to have negative stable, global, and internal causal attributions (Abramson, Seligman, & Teasdale, 1978). One item from the WBPT was chosen to measure learned helplessness with regard to depression (i.e., 'I have always been basically stupid or clumsy and always will be'). A one-way MANOVA was performed with the wellness and depression indexes as dependent variables. Results indicate significance, $F(2, 365) = 17.29$, $p < .001$, Wilk's = .91. The univariate tests indicate significance for both indexes, $p < .001$; for depression, $F(1, 366) = 27.22$, and wellness, $F(1, 366) = 32.73$. These data support the notion that having negative, stable, and global causal attributions, such as the item used for the WBPT, is strongly related to a person's emotional well-being.

Examination of Elliottt and Marmarosh's Hypothesis

Elliottt and Marmarosh (1994) has focused on self-appraised problem-solving skill as being an indicator of how efficient a person is at avoiding depression or improving emotional health. Four items were taken from the WBPT to measure this relationship:

I tend to think a lot about my problems but many times it is not very productive: it doesn't help much;

When I am overwhelmed, I try to break the problem up into component parts and tackle them one at a time;

If there is nothing that I can do about a problem a the time, I don't worry about it. I put it out of my mind as best I can and get on with other things and only think about it when something can be done; and,

When I have a problem I think through the best solution.

These independent variables were entered into a 2 X 2 X 2 X 2 MANOVA with the wellness and depression indexes serving as dependent variables. Results demonstrated

no significant interactions. Three of the measured problem-solving approaches were significant ($p < .05$), but not the approach in which the problem is set aside. For the unproductive thinking approach, $F(2, 340) = 10.37$, Wilk's = .94; for the approach that breaks problems down, $F(2, 340) = 7.60$, Wilk's = .96; and, for the approach the tries to find the best solution, $F(2, 340) = 5.43$, Wilk's = .97. Univariate analyses indicated that these were significant ($p < .01$) for both wellness and depression in all cases.

Examination of Suls and Fletcher's Hypothesis

Suls and Fletcher (1985) considered a personality trait termed "internal awareness." The item from the WBPT that was used to measure the relationship between internal awareness and emotional well-being is taken from their definition of internal awareness. The item states, 'It is part of my personality to be aware of my emotions, the sensations in my body, and my behavior to better understand them and learn from them, without beating myself up for them.' Results of a one-way MANOVA indicated significance for multivariate and both univariate analyses, $p < .001$. The multivariate results are $F(2, 356) = 35.29$, Wilk's lambda = .84. Having "internal awareness" is highly associated with emotional wellness, while not being internally aware is associated with depression.

Summary

The two main reasons for conducting this research were both to obtain a better understanding of emotional well-being, its components and associated coping strategies, and to begin exploring the relationship other aspects of human nature have with emotional well-being. The components of emotional well-being, based on the items that most strongly related to the entire emotional well-being section of the WBPT, can be summarized into five core areas: interpersonal, intrapersonal, level of stress, problem solving, and emotional stability (see Appendix C). These will be expanded upon in the discussion section. With regard to the constructs offered by other researchers' concerning coping skills and emotional well-being, many were supported. For example, this research

supported that focusing on one's depressed mood potentiates depression. As well, problem solving skills were strongly related to emotional well-being. In addition, certain beliefs (e.g., the belief that life is manageable and has meaning, and a sense of having control in life) were strongly associated with emotional well-being,.

In considering the relationship between spiritual, intellectual, physical, and emotional health, it was found that the intellectual index was most strongly associated with the emotional wellness index and that the spiritual index was weakest, however, the correlations were all significant. Recall that the tripartite model of well-being is mind, body, and spirit. For the purposes of this research, mind was divided into two categories: emotional and intellectual. Therefore, it is logical that the intellectual index was most strongly related to the emotional wellness index. This research suggests that intellectual, physical, and spiritual health, are likely to be significant contributors to emotional well-being.

Discussion

This study had two basic purposes. The primary intent of this explorative study was to obtain pertinent information about emotional well-being in order to develop a theory of emotional well-being that both, is readily applicable to the psychotherapy session, and is focused on encouraging emotional wellness, rather than just decreasing the symptoms of depression. With a better understanding of the components of emotional well-being , as well as greater knowledge of the coping skills associated with emotional wellness, professionals can begin to explore therapeutic methods to help clients develop more effective coping skills. The second purpose was to begin exploring other aspects of human nature that may impact emotional well-being. A better understanding of how other aspects of a person influence emotional well-being may help psychotherapists, medical practitioners, and spiritual leaders to treat the entire individual, rather than focusing on only one aspect.

Emotional Well-Being

For this research, it was assumed that depression is diametrically opposed to emotional wellness. This does not include brief reactive depression, or exogenous depression, as all people have depressive reactions to certain events, such as deaths, relationship separations, and severe abuse. That is to say, emotionally well people will experience an acute depression from time to time. There are numerous research articles on depression, but it is only recently that researchers have become interested in psychological wellness. For many decades, the focus of psychology was the relative absence of emotional sickness, which usually required long-term psychotherapy. Currently, however, psychotherapists are being asked to defend their methods and goals, and to work more quickly than ever before. The focus is, therefore, changing from the absence of sickness, to the presence of emotional wellness. Managed care companies push psychologists to keep people out of psychiatric hospitals, and frown on preventable repeat hospitalizations. By using a model of emotional well-being that is based on teachable, discrete coping skills, it provides a focus for the psychotherapist, the client, and, perhaps, managed care companies. The results of this study offer important insights into emotional well-being.

The items for the emotional wellness scale were concerned with emotional stability, close interpersonal relationships, comfort with one's self (self-esteem), low levels of distress, ability to relax, lack of consistent fear and anxiety (contentment), clear thought process (ability to concentrate, make decisions), and a feeling of emotional growth. From a clinician's frame of reference, therefore, one may consider the goal of therapy to include: emotional stabilization skills, learning how to cope with stress, interpersonal skills, intrapersonal skills (comfort with one's self, independence), and effective problem solving skills. Therefore, if a clinician believes that many of the difficulties people have are due to coping skill deficits, then he or she may choose to focus on the person's present coping skill strengths and weaknesses. Not surprisingly,

emotional wellness was shown to increase with age. It is logical to assume that as people obtain life experience they refine their coping skills, as well as add to their coping skill repertoire.

Components of emotional well-being. The present study has provided a solid foundation for increasing our understanding of emotional well-being and has provided a path for clinicians and researchers to follow. This path consists of five components that contribute to emotional well-being: interpersonal skills; intrapersonal skills; emotional stabilization skills; coping with stress; and, problem solving skills.

Psychotherapists may begin teaching effective relationship skills to their clients. This may include education on passive, passive-aggressive, aggressive, and assertive approaches, with a focus on the skills for the latter. It may include skills for establishing boundaries in relationships. People may need to learn specific skills on how to end relationships, or change them, or deepen them. People may benefit from learning levels of self-disclosure and levels of relationship commitments. This may also include the skills to cope with criticism and conflict, how not to be defensive, and how to lessen defensiveness in others. The goal is to teach people step-by-step skills on how to foster healthy relationships, and when and how to end unhealthy relationships.

Why is it that psychologists assume that consistent relationship difficulties are due to character flaws, but when a person responds incorrectly to a math question, they assume, correctly, that it is due to a lack of skill or knowledge? Just like math, coping with other people requires skill and knowledge. Take for example, a woman that has experienced a series of abusive relationships. One could assume pathology consistent with passive-dependency, unresolved conflicts with her abusive father and passive mother, or Borderline Personality Disorder. If one were to approach her from a coping skills perspective, she may need to learn relationship skills and perhaps intrapersonal skills. The assumption is that she was never taught, or shown, appropriate interpersonal

skills. Maybe now clinicians can begin teaching relationship skills designed to help a person obtain healthier relationships.

Intrapersonal skills address a person's ability to accept some control in one's environment, to internally manage life's demands, and work toward a particular commitment, purpose, or goal in life. That is, fulfilling both the demands of life (i.e., bills, chores, and work) and the physical, intellectual, spiritual, and emotional demands (i.e., adequate sleep, nutrition, and time to have fun, relax, and learn). This area of skill includes teaching the person appropriate boundaries so that he or she does not cross into other's boundaries. For example, a women may be confronted with her spouse that is in a bad mood. She may immediately believe it is something she has done (or not done) and that it is her responsibility to get him in a good mood. This is an example of poor boundaries. A client may need to be taught intrapersonal skills if he or she is experiencing "burn-out," or may need to be taught skills to balance life's chores with life's desires when avoidance, or procrastination, is used excessively. This unit is concerned with building self-esteem, self-confidence, and self-worth.

A large proportion of the self-help books on the market focus on the intrapersonal aspects of emotional well-being. The topics include self-esteem building, increasing self-confidence, why we eat when we are emotionally upset, how to conquer shyness, battling loneliness, how to love yourself, and becoming your own best friend. It is logical, therefore, to assume that if people are buying these books, they want to learn useful information and skills that will help them feel more positive about themselves.

Emotional stabilization skills are concerned with smoothing the rises and falls of the emotional roller coaster ride that some people experience. Distraction may be one skill that clinician's may teach to clients. Recall that focusing on one's depressed mood only served to enhance depression. Many people get so wrapped up in their problem that their emotions take over, and logical problem solving becomes nearly impossible. Other skills may include identifying emotional triggers, how to counteract them, how to avoid

them, how to calm down when emotional escalation begins, how to shift attention to the facts, rather than focusing on the emotions. These skills will not only serve to smooth the roller coaster ride of emotions but also help the person begin to engage in an effective problem solving process.

Teaching problem solving skills may not be as simple as one may think. There will be some cookbook-type skills for generic problems that will definitely be useful. Other times, however, the clinician may have to lead the client through the problem step by step. This may include skills to prioritize demands being placed on the individual, chain analysis skills, considering pros and cons, organizational skills, and skills to consider the consequences of actions. It may also include learning time-management skills, learning the importance of being able to think ahead and develop contingency plans, learning how to make realistic goals, and how to break a problem down into single actions.

The concept of teaching skills for coping with stress is not new. There are likely thousands of classes taught every week that focus on stress management. The focus here, however, is concerned with living with the stress that is not likely to change, at least in the near future. This may involve teaching the client to consider the situation from a broader perspective. For example, accepting that people may say "No" to requests, may act annoyingly, or may be different than one desires. Once a client (and therapist) can view people from the perspective that others, usually, do not respond in annoying ways because they are mean, rather, they respond inappropriately because of the result of lack of skill or it is simply their personality, then clients may be less inclined to experience intolerable stress due to the conflicting relationship. The clinician may teach skills to help clients access this broader perspective. Stress endurance skills may include teaching relaxation techniques, positive self-talk, skills to help them decrease worrying, skills to help them delay gratification, reframing techniques, and ways to help them build a "psychological reserve" so that every day stress can be handled with more patience.

The proposed model of emotional well-being, thus, consists of five core elements: interpersonal, intrapersonal, emotional stabilization, problem solving, and stress endurance skills. The accompanying mindset is that people, usually, experience emotional difficulties because of the lack of coping skills. This study does not support the notion that all mental disorders are due to a lack of coping skills, certainly genetics and chemical imbalance play important roles in many mental disorders. People that experience recurrent depressions or personality disorders, however, may benefit from learning more effective coping skills.

This approach to mental health is not unlike the treatment used for certain medical conditions. For example, a person that is diagnosed with diabetes may choose to make several behavioral changes. First, they will be prescribed appropriate medication and will likely have regular checks of their blood. Secondly, they may choose to learn more about dietary and physical modifications that will help them live more comfortably. Living with diabetes, therefore, may become a drastic behavior changing experience. Alternatively, a person may choose only to take their medication and not be concerned with their diet and exercise patterns. Similarly, a person that has chronic depression, or perhaps a personality disorder, may choose to take their prescribed medication, which usually provides some relief. They may also choose to make certain behavioral changes, which consist of fine tuning their coping skills. By fine tuning their coping skills they may be more likely to have longer periods between episodes of depression, or prevent future episodes.

Other pertinent findings regarding emotional well-being. It was also judged important to explore other researchers' suppositions regarding coping, and emotional wellness and depression. Butler and Nolen-Hoeksema (1994) presented research supporting the notion that women were more likely to be depressed than men because of the coping technique they choose, namely focusing on their mood and the potential cause of that mood. Whereas, men are proposed to be more likely to use distraction techniques,

which are judged to be a more effective coping style. The current study supported certain aspects of Nolen-Hoeksema's research. Focusing on one's mood and the potential causes of that mood was strongly associated with depression. The relationship of gender and this coping style was implied but not strong enough to be supported statistically. The present study can only support that brooding is related to depression. The use of distraction did not appear to be influential for well-being in males but appeared to be a factor in women's emotional well-being. That is, women who used distraction techniques were less likely to be depressed.

Distraction can be considered a coping technique that encourages emotional stability which relates to the previously mentioned core elements of emotional well-being. Whereas, brooding can be conceptualized as contributing to emotional instability. These findings offer some support for Butler and Nolen-Hoeksema's suppositions (1994). An important caveat to consider in the interpretations of the conclusions is that these results are based solely on two self-report test items that may not adequately represent the coping skills posed by Butler and Nolen-Hoeksema (1994).

Kobasa (1979) developed the notion of the hardy personality which consists of beliefs that one has some control over his or her environment, is committed to a purpose in life, and views life as a challenge. The hardy personality is presumed to be associated with effective coping skills and wellness. The present study supports the notion of the hardy personality. Interestingly, the proposed components each fit into the intrapersonal category of the core components of emotional well-being offered above. All three likely belong to the category of intrapersonal skill. The idea of being able to exert control over one's environment may be included with such concepts as, self-esteem and self-confidence. That is, if a person has a sense of control, they likely have the skills to exert that control. The notion of commitment to life, may also suggest a sense of purpose. For example, if a person has a sense of purpose then he or she is likely to work toward a specific goal. Thirdly, if a person views the world as a challenge, it implies a sense of

confidence in his or her ability to handle the complications of life and a belief that complications are a natural part of life. Therefore, the research provided by Kobasa and her colleagues (as assessed in the present study by the stated format) provided valuable insights into the treatment of depression and the potential attainment of emotional wellness.

The "sense of coherence" was proposed by Antonovsky (1979) and is similar to the hardy personality. The primary distinction is that Antonovsky proposed comprehensibility of the world rather than the challenge component exhibited in the hardy personality. Antonovsky has, therefore, proposed the following to be important components of well-being: comprehensibility of the world; manageability of life; and, meaningfulness of life. Again, within the limitations of the testing procedures, all three notions were shown to be significantly related to emotional well-being. Each of the three elements might also be considered part of the intrapersonal component of well-being. Therefore, the sense of coherence also provided appreciable information for understanding emotional well-being.

The notion of "learned resourcefulness" posited by Rosenbaum (1990) suggests four characteristics that serve to help insulate people from being overwhelmed by stress. The characteristics include a sense of self-efficacy, problem solving skill, cognitive skills, and the capacity to delay gratification. The results of the present study support that these characteristics are associated with emotional well-being. The caveat must again be stated that the results are based on only four statements from the WBPT that were judged by the experimenter to represent the constructs proposed by Rosenbaum. These characteristics may be compared with the five core areas of well-being presented above. It is logical that cognitive skills and problem solving skills are a part of the problem solving core area. The ability to delay gratification may likely fall into the category of coping with distress. That is, by using skills to help oneself delay gratification, he or she is less likely to become overly anxious and distressed when his or

her needs are not met immediately. Obviously, this will overlap to some extent with emotional stabilization skills. Self-efficacy could be included in the intrapersonal core of emotional well-being.

Learned helplessness as it relates to depression has been researched by Abramson, et al. (1978). They proposed that people that have negative stable, global, and internal causal attributions are more likely to be depressed. This notion was supported in the present study. People that responded to an item judged to represent this belief were more likely to be depressed.

Another avenue of current research concerning wellness is focused on self-appraised problem solving skills (Elliottt & Marmarosh, 1994). For the present study several aspects of problem solving were addressed: unproductive problem solving; breaking a problem into smaller goals; thinking through the best solution; and, not worrying about a problem situation until some action can be taken. Thinking through the best solution and breaking up a problem into attainable goals were most strongly associated with emotional wellness, and unproductive thinking was associated with depression. This research also supports the problem solving skills category as being an important core area of emotional well-being.

Finally, this research considered the notion of internal awareness presented by Suls and Fletcher (1985). Internal awareness refers to the awareness of emotions, the sensations in the body, and one's behavior for better understanding of one's self. Internal awareness was assessed using only one statement from the WBPT. The present study supported that internal awareness is associated with emotional well-being. This awareness may also be considered part of the intrapersonal core of emotional well-being.

The impact of physical, intellectual, and spiritual health on emotional well-being. This explorative study provides only the starting point for other research. All of these aspects of human nature were found to be significantly related. Intellectual health was found to have the closest relationship with emotional well-being. Please note that

intellectual health is not synonymous with intelligence, but rather, the emphases is on a person's desires, and efforts, to learn. The knowledge that these aspects of human nature impact emotional well-being provide support for the holistic approach to treatment. For example, many professionals suggest to a depressed person that regular exercise is good for improving emotional health. This research suggests that having a depressed person do something intellectually stimulating may be of great help to their emotional state. It may be prudent for psychotherapists to obtain information regarding a person's physical self-care habits, daily intellectual stimulation, or spiritual beliefs, thus allowing the therapist to make beneficial adjustments to treatment, or perhaps, necessary referrals.

Future research concerned with emotional well-being. Five core areas of emotional well-being have been identified. The next step is to replicate these findings using a random sampling approach. Interestingly, research by Marsha Linehan (1987) offers support for the presented model of emotional well-being. She has devised a therapy for people with Borderline Personality Disorder that closely resembles the model of emotional well-being presented here. She advocates teaching coping skills to patients with Borderline Personality Disorder. The coping skills are grouped into four units: Distress Tolerance, Interpersonal Effectiveness, Mindfulness, and Emotional Regulation Skills. There are some obvious differences, but important similarities are evident. With research such as Linehan's and the present study, hopefully, more psychotherapists will abandon the notion of character flaws and accept the notion of coping skill weaknesses and strengths. As well, research by Barusch (1988) which provides insight on coping skills that are helpful to elderly spouse caregivers, is a good example of the work that needs to continue, perhaps considering many common stressful situations that people encounter. The caution here is that the therapist needs to be focused on the particular client, because what is useful to one person may not be useful and helpful to another.

Eventually, an emotional well-being test needs to be developed, that is based on the five core areas of emotional well-being. The goal is to devise a concise and user-

friendly instrument that will serve to help both clinicians and researchers establish an estimation of an individual's coping skill strengths and weaknesses for each of the established core areas of emotional well-being. With a good test of emotional well-being, research concerning treatment approaches and effectiveness become easier and more useful. As well, when such a test is developed, a clinician will be able to utilize it to streamline therapy and focus particularly on the weaknesses but also enhance the well-learned coping skills. By focusing research and therapy on coping skills, psychology will be teaching the public emotional wellness skills.

Specific coping skills that apply to each core area of emotional well-being will need to be established. The research community will need to identify, and test, skills that contribute to enhanced emotional well-being. The clinician's task is similar. Coping skills will need to be taught in a way that clients will both understand and use effectively. Each client, of course, will have to modify the skills so that they work for them. By teaching clients effective coping skills, then theoretically, they will be better equipped to handle similar situations in the future.

Concluding Comments

Psychologists will no longer come to the rescue with a bag of tricks consisting of seemingly mystical insights and analysis techniques, only to leave the client when the job is done, packing away the tools. Rather, they will share their knowledge of behavior and of effective coping skills and help the client develop new and effective tools, using a collaborative approach. The idea is simplistic, but may be threatening to some psychologists as it takes the mysticism out of psychotherapy. Obviously, psychologists will still need their bag of tricks to help treat certain conditions that may not be the result of coping skills deficits. The psychologist that follows this model will approach people with the goal of enhancing emotional wellness rather than just decreasing emotional sickness.

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Appendix A

Voluntary Consent Form For Participation
in Dissertation Research Study

Study Topic:

Theories and Assessment of Coping and Well-Being.

Examiner:

Tina-Linnea Nelson, Ph.D. Candidate.
Work phone 402 536 6577.

Introduction:

You are invited to participate in a study designed to explore well-being in the general population. Well-being refers to the level of health on different aspects of an individual's life; such as, physical, spiritual, emotional, and intellectual health. This is more broad than current research that focuses on either depression or wellness, which are the extremes of well-being.

What is involved in participating in this research?

A test has been developed to provide some indication of well-being. It consists of 273 statements that you are to respond to by marking the answer that is appropriate for you. It is necessary to give this test to a large number of people of different age, race, socio-economic status, etc. Your participation is strictly voluntary and you may discontinue at anytime with no coercion or prejudice from the examiner. Your identity will not be recorded on the test so there will be no way to connect your test with your name. Your identity will be kept confidential. Your name will not appear on any documentation other than this form. These forms will be locked in a cabinet until the data has been fully analyzed and is no longer useful. At that time these forms and tests will be destroyed. You will be asked questions concerning habits, beliefs, abuse history, and other questions that you may feel to be sensitive in nature. Participation can in no way affect employment, medical, or educational status. We do not believe there is any special risk associated with your participation in this study.

If you have questions about this study please phone Linnea Nelson at (402) 536-6577 during regular business hours, or leave a message and your call will be returned.

_____ Volunteer's Signature

_____ Witness

_____ Date

Appendix B
The Well-Being Pilot Test
By: Tina-Linnea Nelson

1. Gender
   - A. Male
   - B. Female

2. Race
   - A. Caucasian
   - B. African-American
   - C. American Indian/First Nations
   - D. Hispanic
   - E. Asian
   - F. Other

3. Age
   - A. 17-27
   - B. 28-38
   - C. 39-49
   - D. 50-60
   - E. 61-71
   - F. 72 +

4. I would say that I have the following socio-economic status in my community
   - A. Poverty level
   - B. low level
   - C. lower-middle
   - D. middle
   - E. upper-middle
   - F. upper level

5. I live in an area with approximately the following population
   - A. less than 20,000 people
   - B. 20,000 - 50,000
   - C. 50,001 - 200,000
   - D. 200,001 - 400,000
   - E. 400,001 - 700,000
   - F. 700,001 +

6. Abuse history (mark as many that apply).
   - A. No abuse.
   - B. Alcoholic guardian in which you had regular contact.
   - C. Emotional abuse that was done to you.
   - D. Substantial fighting in home.
   - E. Sexual abuse that was done to you.

7. While growing up my family-life was
   - A. emotionally satisfying
   - B. neither satisfying nor traumatic
   - C. emotionally traumatic

Read the following statements and mark True "T" or False "F" to best describe yourself MOST of the time.

8.	T F	I notice all my mistakes but pay little or no attention to my successes.
9.	T F	I like to do things that I am gifted at like creativity, helping others, building, etc.
10.	T F	I think about the meaning of events in my life.
11.	T F	All in all, I believe that the world is structured, predictable, and explainable (comprehensible).
12.	T F	My sex life is not satisfactory.
13.	T F	There are times when I feel satisfied or content.
14.	T F	I have some doubts from time to time about my higher power.
15.	T F	I feel comfortable with my sense of humour.
16.	T F	I think that I am lazy.
17.	T F	I actively worship, or pray to, a higher power of good (God, Buddha, etc.)
18.	T F	When I'm doing my work I often find that I have gone off on a tangent, or become distracted by something else.
19.	T F	I get physical exercise at least five times per week.
20.	T F	I can be alone and not feel lonely.
21.	T F	I actively worship, or pray to, a higher power of what society would consider "bad" (Satan, etc.).
22.	T F	All religious "good" people are hypocrites.
23.	T F	When someone makes me angry I can deal with it sensibly (e.g., calm down, talk it out, walk away).
24.	T F	When I get an idea that I want to do something I can become very determined to do it.
25.	T F	I tend to think about my past mistakes a lot.
26.	T F	I have been told that I have manic-depression or bipolar disorder.
27.	T F	I have always been basically stupid or clumsy and always will be.
28.	T F	I'm really good at "figuring people out" within minutes of meeting them.
29.	T F	I have healthy intimate relationships.
30.	T F	I have at least two confidants to whom I can tell almost anything.

31.	T F	I have lost my interest or pleasure in all, or almost all, activities most of the day or nearly every day.
32.	T F	I only have myself to blame for most of the bad things that have happened to me.
33.	T F	Many times I feel like I'm on a roller-coaster ride with my emotions.
34.	T F	I'm insightful and tend to know what "makes people tick" even if I have never really met them.
35.	T F	I tend to hide my spiritual beliefs even with my closest friends (whether you are an atheist, worshipper, or not).
36.	T F	As a rule I don't trust people.
37.	T F	I don't think others would describe me as being needy.
38.	T F	When I hear a word that I don't know I try to remember it so I can look it up in the dictionary.
39.	T F	I worship with other people at least monthly.
40.	T F	I have been diagnosed with cancer.
41.	T F	I don't seem to get as happy as other people.
42.	T F	I feel comfortable opening up with people I trust.
43.	T F	I am not good at dealing with emotional problems (confrontation, disagreements, etc.).
44.	T F	I watch, or listen to, the news regularly.
45.	T F	I have headaches regularly.
46.	T F	I think my friends would be surprised if they found out about my spiritual values.
47.	T F	In the late-afternoon my urine is dark yellow.
48.	T F	I speak up right away (or soon after) when someone has said or done something to upset me.
49.	T F	I bite my fingernails.
50.	T F	I meet with other people regularly with similar or different spiritual beliefs so that we can learn from each other.
51.	T F	I feel comfortable with the range of my emotions.
52.	T F	When I'm feeling good, or average for me, I find that I require no, or very little, time for hobbies, time to myself, time with friends, etc.
53.	T F	I am motivated to add to the greater good in the world.

54.	T F	I think that I am assertive.
55.	T F	I have been told that I have high blood pressure.
56.	T F	I get angry at God once in awhile.
57.	T F	I tend to think a lot about my problems but many times it is not very productive: it doesn't help much.
58.	T F	I have a hobby that I engage in at least weekly.
59.	T F	I believe in, and participate in, monogamous relationships (e.g., having only one sexual partner).
60.	T F	When I'm feeling good, or average for me, I don't think much about my mental health.
61.	T F	I am not worthy of love and respect of other people.
62.	T F	I am good at sarcastic humour (putting people down in a "funny" way, etc.) and enjoy doing it.
63.	T F	I like to "just go for it" and have a lot of fun, not caring much about personal safety.
64.	T F	I live life for what "is to come," for the future and not the present.
65.	T F	I seem to fidget a lot lately, which is not usual for me.
66.	T F	I support wearing helmets when riding bikes or motorcycles (for adults and children).
67.	T F	Life is not manageable.
68.	T F	I worship with other people nearly every week.
69.	T F	Some people think I have a drinking (or other drug) problem.
70.	T F	I smoke cigarettes regularly.
71.	T F	I use sleep-aids regularly to help me fall asleep.
72.	T F	I tend to hold grudges.
73.	T F	I stretch before I exercise.
74.	T F	Most of my close friends share my spiritual beliefs.
75.	T F	I'm one of those people that seem to get nearly every cold that passes through town.
76.	T F	I usually sleep well, and get plenty of rest.

77. T F I'm one of those people that like to take on a job all at once. For example, if I wanted to paint the house or clean out the basement or write a term paper, I'd do the job from early in the morning until late at night until the job was done.

78. T F When I have a problem I usually have the ability to control my thoughts and emotions so that I can resolve the situation in the best manner.

79. T F The idea of going to a lecture, workshop or demonstration doesn't interest me, even if it were a topic I liked.

80. T F I tend to keep my feelings to myself.

81. T F When I make a mistake I emotionally beat myself up.

82. T F I tend to act a lot differently depending on the people I am with at the time.

83. T F I drink no more than 3 glasses of water or juice per day.

84. T F When I do something accidentally (trip, spill something, etc.) in front of others, I beat myself up for hours later and/or I feel humiliated.

85. T F I am assertive more than I am aggressive.

86. T F I read fewer than 5 books a year.

87. T F I try to center my life on my higher power (e.g., I think about what would be right with my higher power).

88. T F I get bored often.

89. T F I try to base my goals in reality (I can really reach them).

90. T F I drink more than 10 average-size alcoholic drinks in one week.

91. T F I like to learn.

92. T F I tend to hold in my anger.

93. T F It seems that I have to fight for what I want in life, even the little things.

94. T F I think people are unique and all have an interesting past.

95. T F I express concern and love for people I care about.

96. T F I have problems with one or more areas of my body (knee, back, elbow, skin) from time to time that is not due to injury.

97. T F When I am down-in-the-dumps I focus on my mood and the potential cause of my mood and not on solutions to the problem.

98. T F I am within 19 pounds of the recommended weight for my age, height, and gender.

99. T F I feel well rested upon awakening, like I have had adequate sleep.

100.	T F	I think competition is always healthy.
101.	T F	I am careful about how much fat there is in my diet.
102.	T F	Faith and belief mean the same thing.
103.	T F	When I am overwhelmed, I try to break the problem up into component parts and tackle them one at a time.
104.	T F	I try to listen to others without interrupting or finishing their thoughts.
105.	T F	I love having intellectual discussions with others.
106.	T F	I procrastinate a lot.
107.	T F	I typically express my emotions spontaneously.
108.	T F	I believe that it is good to always be accomplishing something.
109.	T F	I sometimes feel like I don't have emotions.
110.	T F	I can say "No" without feeling guilty.
111.	T F	I approach people aggressively.
112.	T F	I have trouble developing close intimate relationships.
113.	T F	I don't remember the last time I was truly inspired.
114.	T F	I believe that a couple should only engage in sex once they are married.
115.	T F	I am sensitive about hurting others.
116.	T F	I find asking for help difficult.
117.	T F	There are times when I like to say or do things just to make others upset or mad.
118.	T F	I wear seat belts when riding in a car/truck.
119.	T F	I try to find out as much information as I can about a problematic situation.
120.	T F	My values and beliefs guide my actions daily.
121.	T F	I floss my teeth at least once per day.
122.	T F	I believe I can answer a lot of those difficult questions people ask about "God" (e.g., Why is there cancer and AIDS, Why does "God" allow war, etc.).
123.	T F	The average serving of regular margarine (1 tablespoon) contains 1-3 grams of total fat.
124.	T F	I feel upset much of the time.
125.	T F	I worry a lot about what other people think about me.

126.	T F	I can't seem to do anything right.
127.	T F	Lately, I have been thinking about killing myself, or wishing I would die naturally.
128.	T F	I like to meet new people.
129.	T F	I have often hurt animals or people intentionally.
130.	T F	I always seem to be "on the go."
131.	T F	One day I'm extremely happy and the next I can be down-in-the-dumps, only to be happy again in a short while.
132.	T F	Other people cause my emotions (they make me angry, sad, happy, etc.).
133.	T F	Others tend to trust me.
134.	T F	Honestly speaking, I think I'm a better person than most people.
135.	T F	People always seem to take advantage of me.
136.	T F	I smoke marijuana regularly.
137.	T F	I don't mind asking for help when I need it.
138.	T F	I do not have close friends.
139.	T F	I try to see the positive side of situations.
140.	T F	I have a depressed mood most of the day, nearly every day.
141.	T F	I eat meat at least 5 times a week.
142.	T F	I think that the activities that I do (work, pleasure) contribute to my well-being.
143.	T F	I can handle the big crises, it's the everyday hassles that I avoid dealing with.
144.	T F	I have had my license revoked because of impaired driving.
145.	T F	I have a stable emotional life.
146.	T F	People tell me that I over analyze things.
147.	T F	I like to do things with a group of friends (bowling, BBQ, etc.) once in awhile.
148.	T F	Other people tend to have personality conflicts with me.
149.	T F	I take diet pills.
150.	T F	I tend to limit my alcohol intake to three drinks or less at any given time.
151.	T F	I like to help people.

152.	T F	I often exaggerate or lie so that others will like me.
153.	T F	Prayer, or meditation, or time to personally reflect is (are) important to me.
154.	T F	I know that I have a stress-related condition (skin rash, indigestion, pain in area of body, migraines or headaches, etc.) which occurs or intensifies considerably when I am under stress.
155.	T F	I am careful about how much caffeine I consume (e.g., coffee, tea, pop/soda, chocolate, etc.).
156.	T F	I express my personal feelings regularly with my friends.
157.	T F	I read parts of the Bible (holy book), or books of prayers, at least four times a month.
158.	T F	I actively try to learn more about my higher power.
159.	T F	I do not feel alert much of the time.
160.	T F	I usually finish the jobs I start.
161.	T F	I sometimes cry in front of my friends.
162.	T F	I have been in at least one serious accident (hit by car, severe bike accident, serious car crash, etc.) in which I was seriously hurt.
163.	T F	I pray/meditate/personally reflect at least weekly.
164.	T F	Faith and trust mean the same thing.
165.	T F	I smoke or eat a lot more when I am upset.
166.	T F	I seem to be tired a lot of the time, which is not usual for me.
167.	T F	I like to find ways to make people happy without them knowing about it.
168.	T F	Some people think I focus too much on the details and lose the point or waste time.
169.	T F	I am sensitive to others' needs.
170.	T F	Other people have told me that my driving is reckless.
171.	T F	I believe that life has meaning.
172.	T F	When I am down-in-the-dumps I try to distract myself (keep busy, think about something else, etc.).
173.	T F	I sleep less than 6 hours or more than 9 hours nearly every night lately, which is unusual for me.
174.	T F	I believe that I am part of a greater whole.

175. T F I really don't even know what I enjoy doing.

176. T F I laugh often and easily.

177. T F I have rheumatoid arthritis (not juvenile).

178. T F I don't seem to be able to relax.

179. T F I feel safe most of the time.

180. T F The work/activities I do are in agreement with my values and beliefs.

181. T F I take time for myself nearly every day.

182. T F I seem to go along fine for awhile and then blow up (lose my temper all at once).

183. T F I have an ulcer.

184. T F I seem to be nervous a lot of the time.

185. T F For the most part, I am comfortable with myself.

186. T F My friends know my spiritual beliefs.

187. T F I brush my teeth at least twice a day.

188. T F I have a bowel movement no more than once every other day.

189. T F I believe friendships, once established, are always there and require little or no work to maintain.

190. T F I use hallucinogens (LSD, PCP, MDA, etc.) at least once in awhile.

191. T F When I have a task to do I like to get started on it as soon as I can.

192. T F People are just too sensitive, they get their feelings hurt too easily.

193. T F There are times when I'm really enthusiastic about something.

194. T F If there is nothing that I can do about a problem at the time, I don't worry about it. I put it out of my mind as best I can and get on with other things and only think about it when something can be done.

195. T F I worship with other people three times per year or less.

196. T F I tend to procrastinate.

197. T F I seem to move more slowly lately, which is not usual for me.

198. T F I find it difficult to concentrate.

199. T F I feel like I'm growing emotionally.

200. T F I am thankful for my life and what I have.

201.	T F	I think every person is basically boring with few exceptions.
202.	T F	When I'm driving I stay within a few miles (kilometres) an hour of the speed limit.
203.	T F	Some people describe me as being a loner.
204.	T F	I have had a head injury or have been told that I have damage to my brain (by injury, illness, or from birth, etc.).
205.	T F	I am really distressed a lot of the time.
206.	T F	I always seem to be catching up on my responsibilities.
207.	T F	I enjoy being with my friends.
208.	T F	I like to challenge myself intellectually.
209.	T F	I set physical limits for myself so that I don't over-extend my body.
210.	T F	I read the newspaper (or informative magazine) at least once a week.
211.	T F	At times I feel excited.
212.	T F	I like to read national news magazines once in awhile.
213.	T F	I am spiritual only when there are crises in my life.
214.	T F	I am scared and afraid of a lot of things.
215.	T F	I don't think much about how my behavior affects others.
216.	T F	I am 20-40 pounds under or over the recommended weight for my age, height, and gender.
217.	T F	I feel worthless and/or guilty a lot of the time.
218.	T F	I like to hear other people's points of view to learn from them.
219.	T F	I have gained or lost weight recently (more than 5 % of your original weight) without trying.
220.	T F	I try to learn from my mistakes and move on.
221.	T F	I can cry in front of my trusted friends when I'm upset.
222.	T F	When I have a problem I think through the best solution.
223.	T F	I enjoy getting really drunk, so drunk that I pass out.
224.	T F	I keep myself busy, but not too busy.
225.	T F	I don't really think much about the purpose of life.

226.	T F	Something hard to handle has recently happened in my life (death of close individual, divorce, diagnosed with major illness, loss of job, etc.).
227.	T F	I go to work (school) even when I'm really sick, I don't need to stay home.
228.	T F	Other people seem to experience a wider range of emotion than I do.
229.	T F	I enjoy the work that I do (if retired, the activities that you are doing).
230.	T F	I would like to be involved in and learn more about witchcraft or astrology.
231.	T F	I do not feel lonely very often.
232.	T F	I set limits on my time so that I can do pleasurable activities.
233.	T F	I actively try to learn more about my job and/or my hobby.
234.	T F	When I'm upset sometimes I hurt myself (make myself bleed, hit myself, etc.).
235.	T F	I keep my distance (emotionally) from most people.
236.	T F	I am currently being treated for depression.
237.	T F	If I think something is wrong with me, I wouldn't hesitate to go to a doctor, or get some kind of help.
238.	T F	There are times when I feel so afraid (even though there is nothing to be afraid of) that my heart races, I have trouble breathing, I get nauseous, etc.
239.	T F	My emotional health seems to be worse now than in the past.
240.	T F	I feel like I'm stuck in a rut.
241.	T F	I accept that I have imperfections, and always will.
242.	T F	It is part of my personality to be aware of my emotions, the sensations in my body, and my behavior to better understand them and learn from them, without beating myself up for them.
243.	T F	I am uncomfortable when someone pays me a compliment.
244.	T F	I believe in a higher power (God, Satan, Earth mother, fate, etc.).
245.	T F	When there is a problem in one of my relationships I wait for the other person to fix it.
246.	T F	For the most part, I express my feelings as they truly are.
247.	T F	I pray/meditate/personally reflect only when I'm in a crisis situation.
248.	T F	I am not comfortable with my eating patterns.
249.	T F	Some people say I exercise too much.

250. T F I believe a person should be nice to all people, no matter what.

251. T F I can handle the everyday problems, it's the big problems that I avoid.

252. T F My close friends tell me I need to slow down.

253. T F I have a hard time concentrating and/or making decisions much of the time lately, which is unusual for me.

254. T F I am so busy that I almost never get a chance to sit still.

255. T F When I am hurt or sick I usually tough it out, without consulting my medical doctor, even when others suggest it.

256. T F I get physical exercise at least three times per week (appropriate for my age).

257. T F I feel hopeful about the future.

258. T F I think that I mature psychologically after making mistakes.

259. T F I think it's good to put others' needs before my own.

260. T F Society would consider me to be obese.

261. T F I am good at dealing with intellectual problems (budgeting money, organizing my time, etc.).

262. T F If I can't do something well, I won't do it even if I like the activity.

263. T F I think it is selfish to take time for myself, even when I know it could be helpful.

264. T F I binge eat (consume a large amount of food) and purge (vomit) on at least a semiregular basis.

265. T F I have puzzling thoughts that sometimes concern me.

266. T F Sometimes it is hard for me to think clearly.

267. T F I notice that part of my body has to be moving at all times (leg bounces, fidgeting hands, etc.).

268. T F I have nightmares regularly.

269. T F I think that I could solve a lot of the world's problems if I were given the opportunity.

270. T F There are times when I stay up for days and require very little sleep.

271. T F At times I see or hear things that others do not seem to see or hear.

272. T F I sincerely believe that people are out to get me.

273. T F When people make me angry I just take it at the time but I make them pay in other subtle ways.

Appendix C

Wellness Index

I tend to think about my past mistakes a lot.

Many times I feel like I'm on a roller-coaster ride with my emotions.

I feel comfortable with the range of my emotions.

I tend to act a lot differently depending on the people I am with at the time.

When I do something accidentally (trip, spill something, etc.) in front of others, I beat myself up for hours later and/or I feel humiliated.

I have trouble developing close intimate relationships.

I feel upset much of the times.

I worry a lot about what other people think about me.

I can't seem to do anything right.

I have a stable emotional life.

I do not feel alert much of the time.

I really don't even know what I enjoy doing.

I don't seem to be able to relax.

I seem to go along fine for awhile and then blow up (lose my temper all at once).

I seem to be nervous a lot of the time.

For the most part, I am comfortable with myself.

I am really distressed a lot of the time.

I am scared and afraid of a lot of things.

My emotional health seems to be worse now than in the past.

I feel like I'm stuck in a rut.

Sometimes it is hard for me to think clearly.

Appendix D

Depression Index

I have lost my interest or pleasure in all, or almost all, activities most of the day or nearly every day.

I feel well-rested upon awakening, like I have had adequate sleep.

Lately, I have been thinking about killing myself, or wishing I would die naturally.

I have a depressed mood most of the day, nearly ever day.

I seem to be tired a lot of the time, which is not usual for me.

I sleep less than 6 hours or more than 9 hours nearly every night lately, which is unusual for me.

I seem to move more slowly lately, which is not usual for me.

I find in difficult to concentrate.

I feel worthless and/or guilty a lot of the time.

I have a hard time concentrating and/or making decisions much of the time lately, which is unusual for me.

I feel hopeful about the future.

Appendix E

Note: This Factor analysis with varimax rotation is organized so that the variables on each page represent the items that the judges chose. This page represents the items that the judges categorized as belonging to the Emotional section. Nearly all the items loaded on factor 1.

Variable	F1	F2	F3	F4	Communal
25	.44				.23
33	.66				.44
51	.58				.39
82	.40				.19
84	.50				.28
112	.41				.27
124	.67				.47
125	.53				.28
126	.52				.29
145	.69				.48
159	.58				.35
175	.46				.26
178	.51				.29
182	.44				.20
184	.61				.37
185	.58				.36
205	.72				.56
214	.56				.32
239	.55				.34
240	.47				.25
266	.57				.33
31	.40				.25
99	.49				.29
127	.30				.14
140	.46				.31
166	.52				.27
173	.36				.16
197	.25				.07
198	.59				.36
217	.72				.53
253	.61				.39
257	.49				.32
% var	11.2				
cum %	11.2				

Note: These variables represent the items that the judges categorized as belonging to the Spiritual section. The majority loaded on factor 2.

Variable	F1	F2	F3	F4	Communal
10	-.03	.15	.10	.45	.23
14	-.20	-.37	.02	-.10	.19
17	-.02	.67	.13	.22	.52
21	.16	-.10	.38	-.18	.21
35	.24	.24	-.05	.19	.15
39	.05	.73	.12	-.04	.55
46	.10	.19	.11	-.10	.07
50	-.00	.56	-.03	.20	.35
53	.11	.11	.25	.41	.25
56	-.27	.10	.00	.09	.09
59	.07	.15	.03	-.06	.03
68	.02	.77	.13	-.01	.61
74	.07	.35	.18	.17	.18
87	.03	.57	.02	.30	.41
102	-.01	-.16	-.08	.05	.04
114	.15	.44	.09	-.16	.25
120	.26	.21	.09	.31	.22
122	-.06	-.23	.09	-.04	.06
153	.07	.48	.14	.46	.47
157	.01	.79	-.04	.05	.62
158	.10	.58	.02	.28	.42
163	.00	.60	.15	.33	.49
164	.01	.22	.01	-.03	.05
174	.05	.25	.14	.45	.29
180	.32	.06	.19	.13	.16
186	-.15	-.42	.20	-.19	.28
195	.10	.21	.06	-.16	.08
200	.40	.04	.17	.23	.24
213	.17	.29	.08	.23	.17
225	-.01	.27	.04	.49	.32
230	.06	.15	.34	-.01	.14
244	-.00	-.37	-.22	-.21	.23
247	.22	.21	.16	.18	.15
% var		5.6			
cum %		16.8			

Note: These variables represent the items that the judges categorized as belonging to the Physical section. The majority of the items loaded on the third factor.

Variable	F_1	F_2	F_3	F_4	Communal
19	.13	-.19	-.04	.14	.08
63	.06	.10	.56	.01	.32
66	.07	-.03	.28	.09	.09
69	.19	.03	.55	-.09	.35
70	.08	.15	.37	-.04	.16
73	.03	-.18	-.07	.23	.09
83	.06	.08	-.04	.27	.09
90	-.03	.09	.41	.12	.20
98	.05	-.37	.08	.21	.20
101	.00	-.04	.37	.31	.23
118	-.02	.09	.34	.11	.14
121	.01	-.03	.07	.32	.11
123	-.06	.02	-.03	.07	.01
136	.15	-.02	.59	-.11	.38
141	-.10	.02	.08	.18	.05
144	.11	-.08	.55	-.07	.32
149	.00	-.11	.22	-.05	.06
150	.06	.13	.43	.14	.23
155	-.05	.11	.23	.30	.16
170	.20	.08	.40	.12	.22
187	.07	-.10	.16	.31	.14
188	.03	.02	.10	-.25	.07
190	-.07	.02	.59	.12	.37
202	.02	.10	.12	.12	.04
209	-.01	.09	.14	.28	.11
216	.07	-.41	.04	.19	.21
223	.07	-.04	.66	.08	.44
227	.03	.12	.19	.10	.06
237	.26	.03	.16	.31	.19
249	.09	.10	.32	-.02	.12
255	.23	.07	.24	.30	.21
256	-.19	.18	-.09	-.24	.13
260	.14	-.38	.07	.20	.21
% var			3.7		
cum %			20.4		

Note: These variables represent the items that the judges categorized as belonging to the Intellectual section. The majority of these items loaded on the forth factor.

Variable	F_1	F_2	F_3	F_4	Communal
38	.04	.11	.06	.41	.18
44	.14	-.01	-.00	.19	.05
79	.10	-.09	.31	.12	.13
86	.05	-.08	-.02	.32	.11
91	.06	.00	-.12	.34	.13
105	-.03	.10	.23	-.41	.24
119	.20	.04	.09	.28	.13
208	.12	-.18	-.09	.50	.31
210	.22	-.04	.07	.14	.07
212	.20	.01	-.01	.26	.11
218	.09	-.06	.13	.38	.17
233	.36	-.08	.06	.36	.26
261	.24	-.02	.10	.13	.08
% var				3.2	
cum %				23.7	

FACTOR	1	2	3	4
1 (emo well-b)	.85	.29	.31	.32
2 (spiritual)	-.46	.82	.16	.30
3 (physical)	-.27	-.43	.80	.33
4 (intellectual)	-.05	-.24	-.49	.84